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ABSTRACT

This manual is designed to help train substance abuse treatment counselors to conduct a brief five-session treatment intervention for adolescents with cannabis use disorders presenting for outpatient treatment. It combines two sessions of motivational enhancement therapy provided individually and three sessions of cognitive behavioral therapy provided in a group format. The program is referred to as MET/CBT5. Although this will be one of the first applications of these approaches to adolescent treatment, related brief intervention approaches with adults have proved very effective. In the Cannabis Youth Treatment study, the approach was also an efficient intervention because its personalized feedback report was based on the intake assessments already done as part of the research protocol. The treatment described in this manual was designed to address the problem of marijuana use by adolescents. Section I reviews the scope, effects, and patterns of the marijuana problem. Section II provides a brief overview of the Cannabis Youth Treatment project for which this manual was developed. Section III covers the scientific basis for this intervention. Section IV provides step-by-step procedures for actually implementing this treatment protocol. Five appendixes contain therapist session reports, supervisor session rating reports, poster facsimiles, personalized feedback reports, and a study on clinical management of a field trial of five outpatient treatments for adolescent substance abuse. (Contains 67 references.) (GCP)

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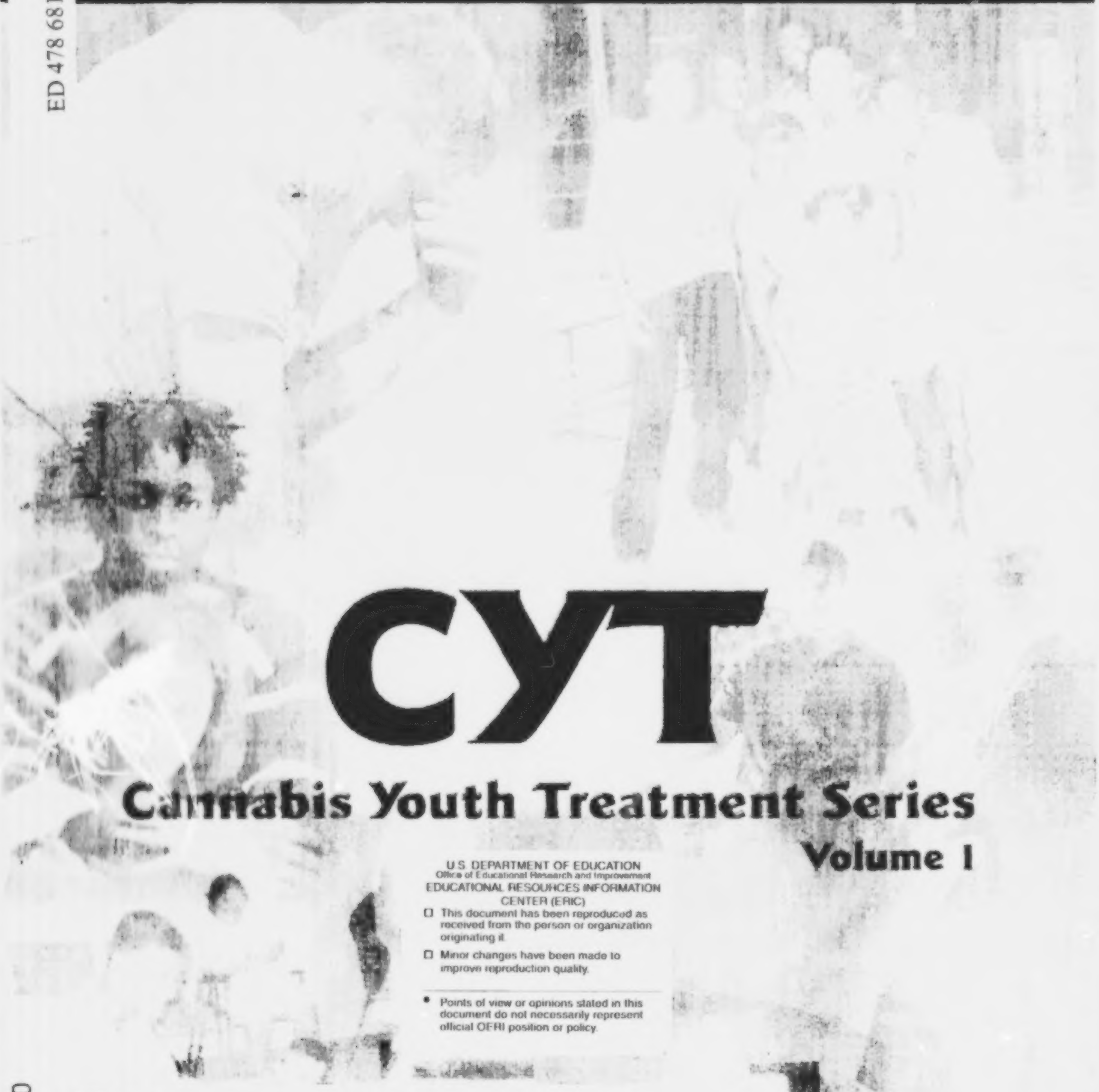

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Cannabis Youth Treatment Series

Volume 1

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Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users:
5 Sessions

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CYT

Cannabis Youth Treatment Series
Volume 1

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The opinions expressed in this document are solely those of the authors and do not represent official positions of CSAT or any other governmental agency. While studies of a combined motivational enhancement therapy and cognitive behavioral therapy (MET/CBT) approach are promising, this treatment protocol was tested with adolescents for the first time as part of this study. The findings from the CYT study will be made public in 2001. Appendix 5 presents a detailed account of the CYT study.

For further information about this manual, please contact the MET/CBT5 work group chair, Dr. Ronald Kadden, at 860-679-4249 (Kadden@psychiatry.uchc.edu) or Dr. Susan Sampl at 860-679-4715 (Sampl@psychiatry.uchc.edu). For further information about the Cannabis Youth Treatment Project please visit our Web site (www.chestnut.org/CYT) or contact the Steering Committee Chair, Dr. Michael Dennis, at 309-827-6026 (Mdennis@chestnut.org).

To order copies of this manual or any other manuals in this series, contact the National Clearinghouse for Alcohol and Drug Information (NCADI) at 800-729-6686, 800-487-4889 (TDD), (www.health.org). The manuals also will be available to download from http://www.samhsa.gov/csat/csat.htm.

Manuals in the Cannabis Youth Treatment (CYT) Series

Sampl, S., & Kadden, R. *Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions, Cannabis Youth Treatment (CYT) Series, Volume 1.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. BKD384

Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users. Cannabis Youth Treatment (CYT) Series, Volume 2.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. BKD385

Hamilton, N. L., Brantley, L. B., Tims, F. M., Angelovich, N., & McDougall, B. *Family Support Network for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 3.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. BKD386

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Liddle, H. A. *Multidimensional Family Therapy for Adolescent Cannabis Users, Cannabis Youth Treatment (CYT) Series, Volume 5.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. BKD388

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I. Introduction and Background

Introduction and Organization

This manual is designed to help train substance abuse treatment counselors to conduct a brief five-session treatment intervention for adolescents with cannabis use disorders presenting for outpatient treatment. It combines two sessions of motivational enhancement therapy provided individually and three sessions of cognitive behavioral therapy provided in a group format. The program is referred to as MET/CBT5. Although this will be one of the first applications of these approaches to adolescent treatment, related brief intervention approaches with adults have proved very effective (Bien, Miller & Tonigan, 1993; Miller et al., 1995; Miller & Rollnick, 1991; Siegal, Rapp, Fisher, Cole & Wagner, 1993; Stark & Kane, 1985; Stephens, Roffman & Simpson, 1994; Zweben, Pearlman & Li, 1988). In the CYT study, the approach was also an efficient intervention because its personalized feedback report was based on the intake assessments already done as part of the research protocol.

The treatment described in this manual was designed to address the problem of marijuana use by adolescents. Section I reviews the scope, effects, and patterns of the marijuana problem. Section II provides a brief overview of the Cannabis Youth Treatment project for which this manual was developed. Section III covers the scientific basis for this intervention. Section IV provides step-by-step procedures for actually implementing this treatment protocol.

Scope and Significance of the Marijuana Problem

Although marijuana use has dropped slightly in the past few years, it is still the most widely used and most readily available illicit psychoactive substance in the United States (Office of Applied Studies, 2000). In 1998, the rate of marijuana use during the month preceding the survey was more than twice that of all other drugs combined (8.3 percent vs. 4.0 percent) and higher than the rate of getting drunk (7.7 percent). Moreover, the rates of marijuana use for 8th graders are twice as high as the rates in 1992. The rate of daily use of marijuana is higher than the rate of daily use of alcohol, and that rate has not gone down (Monitoring the Future, 1999). Furthermore, similar trends in marijuana use are reported in regional surveys of junior and senior high school students (Godley et al., 1996; Hartwell et al., 1996; Markwood, McDermiet & Godley, 2000). Marijuana use has historically been inversely related to an adolescent's perceived risk of using it (Johnson, Hoffman & Gerstein, 1996), and currently this perception among 12th graders is at the lowest point since 1982 (Monitoring the Future, 1999). Unfortunately, these perceptions do not match the facts.

Relative to nonusers, adolescents who used marijuana (and typically alcohol) weekly were 3 to 47 times more likely to have a host of problems including symptoms of dependence, emergency room admissions, dropping out of school, behavioral problems, fighting, non-drug-related legal problems, other legal problems, and being arrested. Unfortunately, fewer than 1 in 10 adolescents with past-year symptoms of dependence received treatment (Dennis & McGeary, 1999; Dennis, Godley & Titus, 1999). From 1992 to 1997, the number of adolescents presenting to publicly funded treatment for marijuana problems increased more than 200 percent; in 1997, 81 percent of adolescents admitted had a primary, secondary, or tertiary problem with marijuana (Dennis, Dawud-Noursi & Muck, in press; Office of Applied Studies, 1999). Marijuana is also the leading substance mentioned in adolescent emergency room admissions and autopsy reports and is believed to be one of the major contributing factors to violent deaths and accidents among adolescents; it has been reported to be involved in as many as 30 percent of adolescent motor vehicle crashes, 20 percent of adolescent homicides, 13 percent of adolescent suicides, and 10 percent of other unintentional injuries among adolescents (Centers for Disease Control and Prevention, 1997; McKeown, Jackson & Valois, 1997; Office of Applied Studies, 1995).

An additional danger associated with marijuana use and observed in adolescents is a sequential pattern of involvement in legal and illegal drugs (Kandel, 1982). Marijuana is frequently a stepping stone that bridges the gap between cigarette and alcohol use and use of other drugs (e.g., cocaine, heroin) (Kandel & Faust, 1975). This stagelike progression of substance abuse, known as the gateway phenomenon, is common among youth from all socioeconomic and racial backgrounds (Kandel & Yamaguchi, 1993). This pattern has also been observed in French and Israeli cohorts (Adler & Kandel, 1981) and has been confirmed in a longitudinal cohort followed from ages 15 to 35 (Kandel et al., 1992). In sum, adolescent marijuana use is intimately linked to future drug involvement. Less serious experimental use portends a decline in later use of all drugs, whereas more serious use often snowballs into involvement with increasingly addictive and potent drugs.

Effects of Marijuana Use

The physical effects of marijuana use include fluctuations in blood pressure, decreased salivation, mild unsteadiness, impaired coordination, hunger, drowsiness, slowed speech, and respiratory difficulties (Cohen, 1979; Hall, 1995; National Institute on Drug Abuse, August 1986), a decrease in the immune response, suppression of testosterone production in males (Cohen, 1979), and a decrease in respiratory vital capacity.

The effect of marijuana use during adolescence on central nervous system development remains unclear. Adolescents abstaining after chronic marijuana use have shown evidence of persistent short-term memory impairment on neuropsychological tests (Millsaps et al., 1994). Pope and Yurgelun-Todd (1996) have recently demonstrated an indirect association between the frequency of marijuana use among college students and cognitive impairment on tests involving card sorting and word learning. These effects are likely to have a significant impact on academic functioning. Whether neuropsychological deficits preceded the onset of drug use or were the result of long-term exposure to marijuana is unclear. Clinical studies suggest that longer term and/or heavier use of marijuana is directly associated with losses of abstract and logical thinking, the ability to focus attention and filter out irrelevant information, and the ability to resolve normal emotional conflicts, mental confusion, and memory problems (Lundvqist, 1995; Solowij, 1995; Solowij et al., 1995). These studies also suggest that it may take 6 to 12 weeks for even partial recovery of cognitive functioning to occur and that this process is prolonged when there is any interim use.

A commonly noted effect of chronic marijuana use is amotivational syndrome, characterized by apathy, decreased attention span, poor judgment, diminished capacity to carry out long-term plans, social withdrawal, and a preoccupation with acquiring marijuana (Cohen, 1980, 1981; Schwartz, 1987). Amotivational syndrome is attributed to heavy cannabis use and has been observed in adolescents (Schwartz, 1987). However, Musty and Kaback (1995) reported that amotivational symptoms in heavy marijuana users between the ages of 19 and 21 might actually be due to co-occurring depression. Whether amotivational syndrome is a primary or a secondary diagnosis in subpopulations of marijuana abusers has not yet been resolved.

Marijuana use has also been associated with a wide variety of social-psychological problems. Rob and colleagues (1990) compared adolescent marijuana users and nonusers on a number of psychosocial factors. Marijuana use was associated with poorer family relationships, poorer school performance, and higher levels of school absenteeism. Other illicit drugs were used almost exclusively by marijuana users, rather than those who did not use marijuana, and marijuana users were more than three times as likely as nonusers to be sexually active, to drink alcohol three or more times per week, and to smoke cigarettes. Serious marijuana use is associated with a multitude of behavioral, developmental, and family problems (Kleinman et al., 1988), including conduct disorder, crime and delinquency, school failure, unwanted pregnancy, and escalating drug involvement (Donovan & Jessor, 1985; Farrell et al., 1992; Hawkins et al., 1992; Jessor & Jessor, 1977).

Patterns of Substance Use

Anecdotal and longitudinal studies have suggested that the age of onset for regular marijuana use most frequently occurs during early adolescence (before age 15) and is almost always completely intertwined with alcohol use (Hops, 1998; Patterson, 1998). Public domain data from 5,143 adolescents surveyed for the Office of Applied Studies (1996) and 1995 National Household Survey on Drug Abuse (NHSDA) show that after age 15, daily use stabilizes at a rate of about 2 to 3 percent, weekly use at about 3 to 4 percent, and monthly use at about 6 to 7 percent. Parallel data for alcohol use are consistent with the literature and suggest an early pattern of onset. Weekly use increases from less than 1 percent at age 12, to 3 percent at age 14, to 10 percent at age 18. Daily use increases from 4 percent at age 12, to 7 percent at age 14, to 9 percent at age 18. Thus, for both marijuana and alcohol, adolescence is clearly a significant period both for initial use and for increasingly more frequent rates of use.

With regard to comorbidity, over two-thirds of the monthly and weekly marijuana users are drinking alcohol—with a third drinking it daily or weekly. Among the daily marijuana users, 27 percent were drinking weekly and 35 percent were drinking daily. Thus, marijuana and alcohol use is starting at similar times, and patterns of their use are largely intertwined.

II. Background on the CYT Cooperative Agreement

MET/CBT5 was developed as a brief intervention to be tested at four treatment sites within the Cannabis Youth Treatment study. Section III of this manual describes the rationale for choosing the elements of the MET/CBT5 therapy. The following description illustrates the context in which MET/CBT5 was developed.

Goals and Objectives

The purpose of the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Cannabis Youth Treatment Cooperative Agreement was to test the relative effectiveness and cost-effectiveness of a variety of interventions targeted at reducing/eliminating marijuana use and associated problems in adolescents and to provide validated models of these interventions to the treatment field. The target population was adolescents with cannabis use disorders of abuse or dependence, as defined by the American Psychiatric Association (1994), who were assessed as appropriate for treatment in outpatient settings.

Overview of Study

The study was conducted in collaboration with staff from Chestnut Health Systems (CHS-MC) in Bloomington and Madison County, Illinois, the University of Connecticut Health Center (UCHC) in Farmington, Connecticut, Operation Parental Awareness and Responsibility (PAR) in St. Petersburg, Florida, and the Children's Hospital of Philadelphia (CHOP), Pennsylvania. It involved five manual-based, expert supported treatment conditions:

- **MET/CBT5**—This is the five-session treatment described in this manual. It comprises two individual sessions of motivational enhancement therapy (MET) and three group sessions of cognitive behavioral therapy (CBT). The MET sessions focus on factors that motivate clients to change. In the CBT sessions, clients learn skills to cope with problems and meet their needs in ways that do not involve turning to marijuana or alcohol.

- **MET/CBT5+CBT7**—This treatment is composed of the complete MET/CBT5 treatment combined with seven supplemental cognitive behavioral sessions covering additional coping skills topics.

- **FSN**—The Family Support Network (FSN) treatment consists of the MET5+CBT7 treatment combined with additional support for families (home visits, parent education meetings, parent support group), aftercare, and case management.

- **ACRA**—The Adolescent Community Reinforcement Approach (ACRA) is composed of 12 individual sessions with an adolescent and the adolescent's parent, caregiver, or concerned other. The focus is on learning alternative skills to cope with problems and meet needs with an emphasis on the adolescent's environment. Concerted effort is made to change the environmental contingencies—both positive and negative—related to substance use.

- **MDFT**—Multidimensional Family Therapy (MDFT) is a family-focused treatment that includes 12 weekly sessions to work individually with adolescents and their families. MDFT focuses on family roles, other problem areas, and their interactions.

These treatments can also be grouped in three different ways. First, they vary by mode, with the first three being combinations of individual and group approaches and the last two being purely individual treatment approaches. Second, the MET/CBT and ACRA interventions were based on behavioral treatment approaches, while the FSN and MDFT interventions were based on family treatment approaches. Third, the treatment conditions were expected to vary in terms of resource intensity and cost, with the MET/CBT5 intervention expected to be the least costly therapy to implement.

At each site, approximately 150 adolescents were systematically assigned to one of three conditions. At ARC and PAR, they were assigned to the brief MET/CBT5 or to one of the two other individual/group combinations, MET/CBT5+CBT7 or FSN. At CHS-MC and CHOP, adolescents were assigned to the brief MET/CBT5 treatment or one of the two individual approaches, ACRA or MDFT. Thus, all five conditions were replicated in two or more sites, with the MET/CBT5 condition implemented at all four sites. All clients were assessed at intake and at 3, 6, and 9 months. To validate clients' responses, urine tests and collateral assessments are also done at intake and at 3 and 6 months.

The general research design document prepared by Dennis and colleagues describes the overall research plan in greater detail (Dennis, Titus, Diamond, Donaldson, Godley, Tims, Webb, Kaminer, Babor, French, Godley, Hamilton, Liddle & Scott, under review). The project's Web site (www.chestnut.org/CYT) can be accessed for further information about the CYT project.

Client and Provider Information

Target Population

MET/CBT5 is designed for the treatment of adolescents between the ages of 12 and 18 with problems related to marijuana use, as indicated by one of the following:

- Meeting criteria for cannabis abuse or dependence
- Experiencing problems (including emotional, physical, legal, social, or academic problems) associated with marijuana use
- Using marijuana at least weekly for 3 months.

Although this treatment includes suggestions for addressing both drug and alcohol use, it is not designed for treating adolescents with polysubstance dependence or those who are heavily using other substances as well as marijuana. In the CYT study, adolescents were excluded from the study who drank alcohol on 45 or more of the previous 90 days or who used another drug on 13 or more of the previous 90 days.

MET/CBT5 should not be used to treat adolescents

- Requiring a level of care that is higher than outpatient treatment
- With a social anxiety disorder severe enough to prevent participation in group therapy sessions
- With a severe conduct disorder
- With an acute psychological disorder severe enough to prevent full participation in treatment.

In the CYT study, this treatment was effectively implemented with adolescents with mixed demographic characteristics such as race, age, socioeconomic group, and gender, as well as from different geographic regions. When treating clients, therapists need to be culturally aware of and sensitive to the client group so they can provide relevant examples and use language that is understood by the clients in the therapy session.

Likely referral sources of potential MET/CBT5 clients are parents, the justice system, school personnel, and medical or mental health care providers. Self-referral is infrequent.

Level of Care

MET/CBT5 is appropriate for use as either an outpatient treatment (ASAM level 1) or early intervention (ASAM level 0.5).

MET/CBT5 can be used by organizations that provide outpatient care, including mental health clinics, youth social service agencies, and mental health private practice settings. Other organizations such as community centers, schools, or general medical settings may appropriately implement MET/CBT5 if they have properly trained staff. Medical settings may be particularly well suited for implementation of MET/CBT5 as an early intervention.

III. Background of the MET/CBT5 Treatment

The MET/CBT5 approach was designed to be an effective brief treatment approach for cannabis-abusing adolescents. The course of treatment consists of two individual motivational enhancement therapy (MET) sessions, followed by participation in three group cognitive behavioral therapy (CBT) sessions. The reasons for choosing a brief treatment model, as well as the background for the MET and CBT treatment models, are described in this section.

Rationale for Brief Treatment

Stephens and Roffman (1996) compared an 18-session relapse prevention support group approach for the treatment of marijuana problems with a 2-session individualized assessment and intervention approach. The latter included a feedback report based on data collected in pretreatment assessments, discussion of the client's marijuana use and related problems using motivational interviewing principles, and development of a plan for change. The results of the study indicated substantial reductions in marijuana use for both active treatments and no evidence of posttreatment differences between the two approaches in terms of abstinence rates, days of marijuana use, severity of problems, or number of dependence symptoms. Although conclusions regarding null differences must be limited, the large sample sizes and the substantial differences in intensity of the treatments argue for an equivalent efficacy of the two conditions. The results suggest that a minimal intervention approach may be more cost-effective for a marijuana-abusing population than an extended group counseling approach. That study, along with others indicating the general effectiveness of brief interventions for some psychiatric disorders and substance abusers, was an important factor in the decision to test relatively brief interventions in large samples of adults (the companion study to this one) and adolescents (this study) at diverse locations nationally.

Basis for MET

In the addictions field, the search for critical conditions that are necessary and sufficient to induce change has led to the identification of six critical elements (Miller & Rollnick, 1991):

- Feedback regarding personal risk or impairment
- Emphasis on personal responsibility for change
- Clear advice to change
- A menu of alternative change options
- Therapist empathy
- Facilitation of client self-efficacy or optimism.

Therapeutic interventions containing some or all of these elements have been effective in initiating change and reducing alcohol use (Bien, Miller & Tonigan, 1993).

The MET approach is further grounded in research on processes of change. Prochaska and DiClemente (1984) describe five stages of change that people progress through in modifying problem behaviors (the stages of precontemplation, contemplation, determination, action, and maintenance). The MET approach assists clients in moving through the stages toward action and maintenance.

In sum, MET is based on motivational principles and has been utilized increasingly in clinical interventions and research, primarily in the alcoholism field. Recently it has also been included as a component in the study that is a companion to the present one—evaluating brief treatments for adult marijuana abusers.

The MET sessions included in MET/CBT5 are planned as individual therapy sessions for a number of reasons. First, motivational enhancement therapy is designed to be an individual approach in which the therapist works with each client regarding that client's own specific reasons for considering change. Most previous effective demonstrations of motivational enhancement therapy have utilized an individual therapy format (Miller et al., 1995; Steinberg et al., 1997; Stephens & Roffman, 1996). This individual approach in MET/CBT5 is reflected in the use of a personalized feedback report, which stimulates discussion of that client's personal concerns and motivations regarding his or her substance use. An individual session is most conducive to a personal discussion. In addition, individual MET sessions are preferable because clients may feel embarrassed about aspects of their substance abuse and related problems; initially they may feel more comfortable discussing these problems individually. Finally, adolescent clients sometimes feel apprehensive about verbalizing their motivation to quit marijuana in front of their peers, for fear that their peers will think that they are not cool. They may have a better chance of contemplating their ambivalence about quitting—and firming up their motivation to address their marijuana use—by working with the therapist privately at first.

This MET/CBT5 therapy is an adaptation of adult treatment to adolescents. The unique developmental tasks of adolescence play a role in substance use disorders and their treatment. Nowinski's 1990 book, *Substance Abuse in Adolescents and Young Adults: A Guide to Treatment*, provides a useful discussion of substance abuse in relation to adolescent development that may help inform therapists using MET/CBT5. Nowinski discusses the primary adolescent developmental task of individuation, in which adolescents develop identities separate from their parents or caregivers. As a part of this individuation process, adolescents are especially likely to question what adults tell them. Using MET style minimizes the likelihood of provoking resistance, which might occur in a highly directive or confrontational therapeutic approach. As a result, the MET approach seems particularly promising for adolescent marijuana abusers. In MET the therapist works with the client's own marijuana use goal, helping to evaluate the benefits and disadvantages of abstinence versus continued use. This process supports the development of self-control, another key developmental task of adolescence (Nowinski, 1990).

The therapists in MET/CBT5 encourage adolescents to try an extended period of abstinence from marijuana to evaluate potential impacts on their lives. In keeping with the MET style though, there is a tolerance for the adolescent's ambivalence about change. The therapist does not try to force abstinence, but helps the client to understand the risks associated with continued use. It is possible that this aspect of MET may be problematic for others in the adolescent's life who may take issue with the therapist not insisting on absolute abstinence. As a matter of fact, many adolescents referred to the treatment may have already been told by other authority figures that they need to abstain from marijuana, with little or no impact on their behavior. It may be that if the therapist were to echo this unilateral message, it too would have little therapeutic impact. It may be useful to educate those in supportive roles around the adolescent client about this aspect of MET to decrease the likelihood that they will react negatively and undermine the therapist's credibility.

Rationale for CBT Treatment

Cognitive behavioral therapy (CBT) is designed to remediate deficits in skills for coping with antecedents to marijuana use. Individuals who rely primarily on marijuana (or other substances) to cope have little choice but to resort to substance use when the need to cope arises. The goal of this intervention is to provide some basic alternative skills to cope with situations that might otherwise lead to substance use. Skill deficits are viewed as central to the relapse process; therefore, the major focus of the CBT groups will be on the development and rehearsal of skills.

The cognitive-behavioral treatment approach used in this intervention is based on that described in *Treating Alcohol Dependence: A Coping Skills Training Guide* (Monti, Abrams, Kadden & Cooney, 1989), a treatment manual that focuses on training in interpersonal and self-management skills. It incorporates treatment elements that have demonstrated clinical effectiveness with alcoholic clients into a manual of interventions aimed at adolescents that can be reliably delivered, monitored, and evaluated.

The focus of CBT treatment is on teaching and practicing overt behaviors, while attempting to keep cognitive demands on clients to a minimum. Repetition is essential to the learning process in order to develop proficiency and to ensure that newly acquired behaviors will be available when needed. Therefore, behavioral rehearsal will be emphasized, using varied, realistic case examples to enhance generalization to real life settings. During the rehearsal periods, clients are asked to identify cues that signal high-risk situations, indicating their recognition of when to employ newly learned coping skills.

Rationale for Group Therapy

Many of the problems or skill deficits associated with substance abuse are interpersonal in nature, and the context of a group provides a realistic yet "safe" setting for the acquisition or refinement of new skills. A number of features associated with group approaches to treatment may facilitate cognitive, affective, and behavioral changes. These factors include the realization that others share similar problems; development of social behaviors; opportunity to try out new behaviors in a safe environment; and development and enhancement of interpersonal learning and trust. Group therapy breaks through clients' isolation, encouraging development of interdependence and identification with other marijuana users, while at the same time avoiding overdependence on the therapist. It also provides the therapist with an opportunity to observe the interpersonal behavior of each group member.

With respect to social skills training, important aspects of the treatment, particularly modeling, rehearsal, and feedback, probably occur more powerfully in a group setting. A client model whose skill level is only somewhat greater than that of a peer observer is likely to have more impact than a skilled therapist is.

A group-therapy format also provides opportunities for behavioral rehearsal and risk taking. Clients benefit from feedback offered by their peers, from discussions of anticipated obstacles to implementation of new skills, and from the case examples provided by fellow clients. There is also the possibility for greater habituation of social anxiety in a group setting.

Group therapy is the most widely used form of treatment delivery for substance abuse rehabilitation. It has a high level of clinical relevance and can be utilized across a variety of treatment settings (e.g., inpatient, outpatient, day programs). Therefore, the results of any study using group therapy are likely to have an impact on current practice. Group therapy is also likely to have a bright future in these increasingly cost-conscious times because of its favorable client-to-staff ratio.

Group therapy can be a particularly powerful modality for teen clients given the importance of peer influence in adolescence (Nowinski, 1990). Feedback from a peer is likely to have greater impact on adolescent clients than similar feedback from the therapist. In the group CBT sessions, therapists encourage adolescent participants to offer other group members positive and constructive feedback. At the same time, adolescent clients are equally susceptible to the negative influence of peers. As a result, it is especially important that the therapist monitor and address any antisocial comments and behaviors that occur in group sessions.

Staff Requirements

Below are the recommended credentials and prior experience requirements for therapists delivering MET/CBT5:

- Therapists should have completed a graduate program for providing clinical mental health services (e.g., M.S.W., Psych.D., Ph.D. in psychology) or an addiction counseling certification program. Some individuals who have completed a bachelor's degree in an area related to mental health can become effective providers of MET/CBT5. However, it is likely that they will require more intensive training and supervision to achieve competency. The more experience bachelor's level therapists have had in the areas listed below, the more likely they will become effective MET/CBT5 therapists.

- Therapists should have a minimum of 1 year's clinical experience working with adolescents.

- Therapist experience in the following areas is also desirable:

  - Working with substance abuse issues
  - Providing behavioral and/or cognitive behavior interventions
  - Providing manual-based therapy.

Therapists with experience in these areas are likely to learn the MET/CBT5 intervention most quickly.

The following recommended caseloads are considered ideal for implementing MET/CBT5 in a clinical setting. One full group of six participants is likely to require approximately one-quarter of a full-time staff person's time (approximately 10 hours per week). For a full-time person who is only seeing MET/CBT5 participants, it is recommended that the caseload be limited to 3 full groups (or 18 participants) rather than 4 full groups, because of the demands involved in keeping track of 18 adolescents' progress and in managing such a caseload. The groups should start on a staggered basis, rather than simultaneously. This way, the initial, heavy demand on clinicians' time to see each participant for two individual sessions will be spread out.

Staffing Recommendations

In the first 2 weeks of the treatment, the therapist sees each participant for two individual therapy sessions. Over the following 3 weeks, the therapist conducts one group therapy session per week. Additional clinician time may be needed to handle emergencies that may occur, to address pragmatic issues such as scheduling and communication, or to make referrals.

Additional staff is needed to conduct and score the initial assessments and prepare the personalized feedback reports. During a group therapy session, another staff person should be available in reasonable proximity to the group therapy room. This staff person (who may be doing other work) could assist in dealing with emergencies or supervising a client who has been asked to leave a group session because he or she is under the influence of drugs or exhibiting disruptive behavior.

Training and Certification Procedures

Therapists should receive 1½ to 2 full days of initial live training in MET/CBT5, with the amount of time needed depending on therapist and project/agency characteristics. Longer training is indicated for less-experienced trainees and/or when therapists will need orientation to the context in which the therapy will be implemented. Also, longer training is indicated when therapists require some extensive training in cultural competence. In the CYT study, the therapists participated in 2 full days of training. The first half-day was an orientation to the CYT project and some common clinical issues applicable to all CYT therapies. The second half of day 1 and all of day 2 focused on teaching MET/CBT5.

The training should be provided by a graduate-level clinician (or a team of clinicians) experienced (minimum of 2 years) in providing, supervising, and training motivational enhancement and cognitive behavioral therapy for substance abusers. The trainer should also have at least 2 years of clinical experience with adolescents. The trainer should have extensive knowledge of the treatment manual contents. The training should include a variety of formats including the following:

- Instruction of rationale and procedures
- Observation of live and/or videotaped examples
- Active practice exercises with feedback.

By varying the formats and by including engaging visual aids, the trainer will be more likely to keep participants actively involved. To increase engagement and clarity, the trainer should welcome and encourage participants' questions and comments.

If MET/CBT5 therapy is to be used in a multisite clinical research project, or in a multisite agency where the intent is consistent delivery and enhanced cohesiveness, it is recommended that the initial training be centralized to one common site and session. This way the therapists at each site will have a common foundation from which to work. During the centralized training, they will have a chance to hear the comments and questions of therapists at other sites and thus will be exposed to a wider range of issues that may come up in applying the intervention. Another likely benefit of centralized training is the potential for it to generate cohesiveness and enthusiasm, whereby participating therapists get the feeling of being a part of the big picture. The trainer can help with this by making enthusiastic comments about being included among therapists who will implement this new therapy, as well as by encouraging participants to interact with those from other sites during practice exercises and breaks.

Supervision and Monitoring Procedures

The person providing the ongoing supervision may have participated as a trainer in the initial training of therapists; however, this in not necessary. It is crucial, however, that the clinical supervisor attends the training. The clinical supervisor should have at least 2 years' experience in delivering and supervising motivational enhancement and cognitive behavioral therapies for substance abusers and in treating adolescents. Experience in supervising manual-based therapies is desirable. If the supervisor has not had experience supervising manual-based therapies, it is recommended that he or she be provided with some related consultation and instruction.

The therapists should receive 1 hour of supervision each week. Prior to certification, this supervision should be on an individual basis. All therapy sessions should be audiotaped or videotaped (with the consent of the adolescent participant and his or her parent/legal guardian). All therapists will need to demonstrate their competence in delivering MET/CBT5. Prior to certification, the supervisor should review every session conducted by the therapist in training and rate each session using the supervisor session rating report (see appendix 2). The supervisor provides feedback regarding the therapist's performance on the skills reviewed in each session, reinforcing his or her relative strengths and identifying skills needing improvement. For those skills needing improvement, the supervisor should provide specific examples, present the rationale for changing technique, and help the therapist generate alternative responses. The therapist is considered certified in providing MET/CBT5 when he or she demonstrates an "adequate" or higher skill level on each of the skills. It is helpful if the supervisor and therapist review portions of the taped sessions, allowing them to discuss the therapist's skills as they hear them together. The therapist also completes a therapist session rating report at the end of each session. The supervisor then reviews the reports and notes any meaningful differences between the therapist's and the supervisor's interpretation of the session. Any differences should be discussed. This will help the therapist with his or her understanding of MET and CBT skills and can improve self-monitoring.

IV. MET/CBT5 Treatment

Overview of MET/CBT5 Protocol

The MET/CBT5 treatment, a brief treatment approach for adolescents with cannabis use disorders, consists of two individual motivational enhancement therapy (MET) sessions, followed by three group cognitive behavioral therapy (CBT) sessions. The two initial individual MET sessions are primarily intended to enhance adolescents' motivation to address their marijuana use and to prepare the clients for the group sessions, with an introduction to functional analysis and the concept of triggers. The purpose of the three group sessions is to assist clients in the development of skills useful for stopping or reducing marijuana use. The CBT sessions focus on the following skills:

- Learning basic skills for refusing offers of marijuana
- Developing a plan for pleasant drug-free activities
- Establishing a social network that will support recovery
- Coping with high-risk situations
- Recovering from a relapse, should one occur.

The table below illustrates the sequence of the five sessions of the MET/CBT5 treatment. Note that the first two (individual) sessions are expected to last for 60 minutes. The final three (group) sessions are scheduled to run for 75 minutes.

Sequence of MET/CBT5 Treatment

Session	Modality	Time Period	Primary Approach	Topics
Session 1	Individual	60 min.	MET	Rapport and motivation building Review of personalized feedback report
Session 2	Individual	60 min.	MET	Goal setting Introduction to functional analysis Preparation for group sessions
Session 3	Group	75 min.	CBT	Marijuana refusal skills, with roleplay practice exercises
Session 4	Group	75 min.	CBT	Enhancing social support network Increasing pleasant activities
Session 5	Group	75 min.	CBT	Coping with unanticipated high-risk situations and relapses

While the first two sessions proceed primarily from a motivational enhancement therapy plan, and the remaining three sessions focus primarily on cognitive-behavioral interventions, it is expected that there will be some overlap of each of these approaches in all five sessions. For example, it is expected that therapists will make effective use of MET interventions, to some extent, across all five treatment sessions.

The establishment of rapport between the therapist and the adolescent clients is essential. The therapist facilitates this rapport by expressing a genuine interest in and nonjudgmental reactions to the adolescents' viewpoints. Therapists are encouraged to use language both familiar and similar to that of the clients. In general, it is recommended that therapists work in accordance with the MET approach across all five treatment sessions, including the three CBT-focused group sessions. The MET approach will be described in detail in the next section.

Therapists are encouraged to draw from their MET skills throughout all five sessions for two important reasons. First, many clients will remain ambivalent about abstinence from marijuana beyond the two planned MET sessions. If the therapist continues to utilize motivation-enhancing reflections and comments, clients will have a greater likelihood of developing motivation to quit smoking marijuana. Second, the MET style of intervention is recommended because it helps avoid the potential authoritarian power struggle of an adult therapist telling adolescent clients what they "must" do. Utilization of the MET style of intervention maximizes the chance for a collaborative therapist-client dialog.

V. Motivational Enhancement Therapy

Motivational enhancement therapy is a therapeutic approach based on the premise that clients will best be able to achieve change when motivation comes from within themselves, rather than being imposed by the therapist. Motivational interviewing, the primary element of MET, was developed by William R. Miller and Stephen Rollnick (1991). It is a transtheoretical model derived from a number of sources, including stages of change theory (Prochaska & DiClemente, 1984), client-centered approaches, and research into what clinician behaviors are associated with the best client outcomes.

Key Concepts

Understanding the following key concepts will assist the clinician in learning and utilizing motivational enhancement therapy.

Ambivalence

Ambivalence refers to the client's mixed feelings about change. For example, the client feels that quitting marijuana is in part a good idea and at the same time, does not want to quit smoking it. MET assumes that ambivalence about change is normal and expected. Changing a problematic behavior can be difficult and anxiety provoking, and it often involves giving up activities and/or relationships that have been enjoyable. So even when people see possible benefits to stopping a negative behavior like substance abuse, they generally feel that they do in part want to change and do not in part want to change. In working with ambivalence, the therapist's task is to help clients acknowledge and discuss these mixed feelings in a way that helps tip the balance in favor of change.

Reflective Listening

Reflective listening refers to all the statements that the therapist makes to clients that express the therapist's understanding of what the client is saying. Reflections can be simple restatements of what the client has said, or they can reflect the meaning or feeling implied by the words. The following example shows how the therapist can respond to the client with any of these types of reflection:

Client: *"My parents are always on my case about getting high. They search my room for my supply, they listen in on my phone calls, and they sometimes even follow me when I go out."*

Here are possible therapist responses:

Using simple reflection (saying what the client has said, but in different words): *"They bug you about smoking marijuana, and they spy on you about it."*

or

Using reflection of meaning (restating the meaning that may be implied by the words): *"As though they're always trying to figure out if and when you're getting high."*

or

Using reflection of feeling (restating what you perceive to be the feeling conveyed in his or her statement): *"It sounds like it's annoying to you, for them to get on your case like that."*

The therapist can use any of the above types of reflections to convey his or her understanding. Remember that when trying to reflect the client's meaning or the feeling connected with his or her words, there is an element of guessing involved. Try to keep the guess close to what the client has said. If the client disagrees with the guess, the therapist should not become defensive or attempt to explain the guess. Instead, the therapist should say something like "Tell me some more, so I'll understand it better."

Accurate reflection is crucial to facilitating change. If clients feel they are truly being understood and accepted by the therapist, they will be increasingly open to considering behavior change. Try to accurately reflect the client's mixed feelings about quitting marijuana. The therapist should use double-sided reflections (reflections that acknowledge both sides of the client's ambivalence) in empathizing with the client's mixed feelings. For example,

> *So you're saying that you really enjoy getting high, but you're worried that it might be hurting your health.*
>
> or
>
> *You're not sure that you want to stop smoking marijuana, but, at the same time, you don't want to get into any more trouble with the law.*

Open-Ended Questions

Open-ended questions invite an elaborative response, while closed-ended questions are those that can be answered by a one-word or very brief answer. Development of motivation is facilitated by the therapist's use of open-ended questions rather than closed-ended questions. Here are some examples of open-ended and closed-ended questions:

Open-Ended Questions	Closed-Ended Questions
Tell me about your early experiences with marijuana.	How old were you when you first smoked marijuana?
How have your friends reacted to your coming to treatment?	Do you have any friends that don't get high? How many?
What led to you coming to treatment?	Did someone force you to come to treatment?

When the therapist uses open-ended questions, he or she elicits more of the client's thoughts and feelings about his or her marijuana use, which are likely to be helpful toward enhancing motivation for change.

The Five Strategies of Motivational Enhancement Therapy

In their book on the principles of motivational interviewing, Miller and Rollnick (1991) have described five main strategies that are used in applying this approach:

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy.

The overall MET approach, and these five strategies, were utilized in two prior national clinical trials: Project MATCH, a nine-site study of three treatments for alcoholism, and the Marijuana Treatment Project, a three-site study of two interventions for marijuana dependence. The following descriptions of the MET strategies are drawn from both the Miller and Rollnick (1991) book and from the treatment manuals from those two studies, respectively: the *Motivational Enhancement Therapy Manual* (Miller et al., 1995) and the *Marijuana Treatment Project Therapist Manual* (Steinberg et al., 1997). They are adapted for use with adolescents.

In applying all the MET strategies described below, keep in mind that good overall therapeutic interviewing skills are the foundation for successful MET. It is crucial that the therapist communicate interest in and acceptance of what the client is saying, while using good listening skills. The following behaviors on the part of the therapist are not good listening and should be avoided or minimized: lecturing, criticizing, labeling, ordering, moralizing, or distracting (Gordon, 1970). If the therapist finds himself or herself becoming extensively involved in those behaviors, he or she should try to put increased emphasis on empathic listening and reflection.

MET Strategy 1: Express Empathy and Acceptance

The MET therapist seeks to communicate respect for the client. Communications that imply a superior/inferior relationship between the therapist and client are to be avoided. This treatment approach is not based on confrontation. It is important that the therapist not give the impression of trying to convince clients of the error of their ways. Rather, the therapist's role is a blend of supportive listener and knowledgeable consultant. Much of MET is *listening rather than telling.*

Empathic listening and accurate reflection are crucial to facilitating change. If adolescent clients feel that they are truly understood and accepted by the therapist, they will be increasingly open to viewing the therapist as a valid consultant to their personal change process.

The MET therapist expresses empathy regarding the client's *ambivalence* about the possibility of stopping marijuana use. The therapist is encouraged to accurately reflect the client's mixed feelings about quitting marijuana. The therapist should use double-sided reflections in empathizing with the client's mixed feelings. For example:

> *So you're saying that you really enjoy the feeling you get from smoking weed, but you're worried that it might be hurting your mind.*
>
> or
>
> *You're not sure that you want to completely stop getting high, but at the same time, you don't want to get into any more legal trouble.*

MET Strategy 2: Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. In employing this MET strategy, the therapist helps clients recognize the discrepancy between the effects of marijuana use on their lives now and how they would like their lives to be. Awareness of this discrepancy may well drive the desire for change.

Here, again, the therapist needs to convey the same respect and empathy for clients as described above. In developing discrepancy, the therapist is ***not*** setting out to convey to the client the impression that "you are a loser because you smoke marijuana," but rather to reflect the client's own stated concerns of how his or her marijuana use is interfering with goal attainment. For example:

> *You'd like to get a job at that store, but you figure smoking pot would make you fail the drug test.*

Therapists may find that many marijuana-smoking adolescents do not have many expressed goals, especially beyond the immediate future. Therapists, therefore, need to listen for what is important to the adolescent in the immediate future. For example:

> *On one hand, you want to keep getting high, but you'd also like to get your mom off your back.*

Even if they are unable to verbalize any specific goals, some adolescent clients may have a vague belief that their lives might be better if they stopped using marijuana. In such cases, it is still helpful for the therapist to reflect this positive expectation back to the client, as in the following example:

> *You want something better from your life than you have now. You're thinking that if you stop smoking weed, your life might start to go better. Is that it?*

Notice that in the previous example, the therapist asks the client whether the therapist has correctly understood the client. This gives the client the chance to correct an inaccurate reflection and, ultimately, may allow the client to feel better understood.

Another type of discrepancy it may be useful to be aware of in working with clients is the discrepancy between how they view themselves currently and how they would like to view themselves. For example, the therapist may reflect to the client:

> *So you're saying that you feel like a loser when you get high so often, and you don't like seeing yourself that way. You'd like to feel good about yourself. Is that it?*

MET Strategy 3: Avoid Argumentation

The MET style explicitly avoids direct argumentation, which tends to evoke resistance. The therapist does not seek to prove or convince by force of argument. When MET is conducted properly, the client and not the therapist voices the arguments for change (Miller & Rollnick, 1991).

If a client becomes increasingly defensive or hostile, the therapist should consider the possibility that his or her previous comments may have played a role in eliciting this reaction. The therapist may have drifted from a MET approach to a confrontational approach. In such a case, the therapist will need to resume the motivational interviewing style.

Another key to avoiding argumentation is to treat ambivalence as normal and to explore it openly using double-sided reflections. Here are some examples:

> *You enjoy partying, but you think it's messing up your life.*
>
> or
>
> *Part of you wants to quit smoking weed, but you're worried that you'll miss it too much.*

These double-sided reflections help the client feel understood. This feeling of being understood decreases the client's defensiveness, and also decreases the likelihood of further argumentation.

MET Strategy 4: Roll With Resistance

The MET strategy does not encourage meeting resistance head on but, rather, rolling with it. When a client voices opposition to change, the therapist may feel tempted to respond with a counter argument. If the therapist does so, however, the client is likely to defend and further strengthen the original stated position. The therapist can roll with the resistance by empathetically reflecting the client's hesitancy to change and then letting the client know that it will be up to him or her to decide if and when to change. Here's an example:

Client: *I just came here because of the court. I don't think smoking a few joints is a problem.*

Therapist: *You had to come here because of the court. You don't want someone else telling you what's a problem for you. Sometimes people find that being in a program like this* *helps them get more information to decide for themselves whether smoking pot is a problem for them or not.*

In the example above, if the therapist had responded with a lecture along the lines of "Smoking pot has already gotten you into trouble with the law, so it surely is a problem for you. . .," the client would likely have become more resistant. When clients are genuinely assured that the decisions about change are up to them, they often become more open to looking at the issue with an open mind.

In assuring clients that the decision is up to them, the therapist need not pretend to ignore contingencies in the environment (e.g., legal implications or parental limits) that make the decision seemingly less optional. Still, the therapist conveys the message to the client that it is the client who decides how these potential consequences will or will not impact on his or her marijuana use.

Sometimes therapists think of resistance as meaning that the client is not cooperating with the treatment. In the MET approach, however, client resistance is seen as a cue that there may be a problem with the therapist's behavior, and so the therapist should try shifting strategies. Similarly, if therapists find themselves in the position of arguing with clients to get them to acknowledge and change, something has gone wrong in the session. It is time to stop and listen to the client.

MET Strategy 5: Support Self-Efficacy

This MET strategy refers to helping develop and support the client's belief that he/she can change. This is important because people who believe that they have a serious problem are still unlikely to move toward change unless there is hope for success. Even if the adolescent client acknowledges that marijuana is a problem, he or she may be disinclined to quit or reduce marijuana use without the belief that he or she can be successful in making that change. The therapist's role is to help clients develop and/or strengthen the sense of self-efficacy—that they can, in fact, stop or reduce their marijuana use.

In order to support self-efficacy, the therapist may ask clients about previous successful experiences they have had in the following areas:

- Previous periods of abstinence from or reduced use of marijuana
- Earlier success in quitting or reducing use of other drugs or alcohol
- Past accomplishment in gaining control over another problematic habit
- Attainment of previous goals that was facilitated once they set their minds to it.

Some clients may not make the connection between these previous accomplishments and the likelihood that they will be successful in meeting their goal regarding marijuana use. They are likely to benefit from the therapist's help in pointing out this relationship. For example:

> *So you're telling me that you were able to stop the bingeing and purging. That's great. Since you were able to stop that problem, which many people find a hard habit to break, you may be equally successful in breaking the marijuana habit.*

Abstinence and Relapse

The Goal of Abstinence

At the same time therapists are maintaining a nonjudgmental approach regarding clients' marijuana use and their current state of readiness for change, MET/CBT5 therapists are encouraged to support the primary goal of this treatment—abstinence from marijuana use. Therapists should be prepared to encourage clients to try abstinence or to work toward abstinence.

Adolescent clients generally vary in their motivation or readiness to stop marijuana use completely, and therapists should be prepared to work with clients' varying degrees of commitment as they move through the processes of change. MET can be a useful therapeutic approach with clients at various stages of motivation and readiness for change. With less motivated clients, the primary therapeutic tasks are helping them recognize possible negative consequences of use and identifying and working through ambivalence. With highly motivated clients, the therapist's focus should be on helping them to verbalize, and thus strengthen, their own motivation for change. The therapist should ask about potential feelings of ambivalence, which if left unaddressed could undermine clients' success.

The therapist should encourage the adolescent to stop other substance use in addition to abstaining from marijuana. The elimination of other drug and alcohol use is considered necessary to maximize clients' ability to learn about themselves while substance-free and to prevent the substitution of other substance use for marijuana. With adolescent clients this position of discouraging other drug and alcohol use also makes the most sense from an ethical standpoint. As described in the introduction to this document, there is also a high rate of alcohol use among adolescent marijuana users. Therapists need to be prepared to address clients' alcohol use in addition to their marijuana use, in order to maximize the chance that the treatment will result in more adaptive functioning by clients. Finally, by attending to issues regarding all drugs and alcohol, not just marijuana, therapists may intervene regarding the gateway phenomenon described in section I. Specifically, they will attempt to decrease the chance that the client's marijuana use leads to the use of other drugs.

Given that some clients may be less than enthusiastic about abstaining from drugs and alcohol, therapists should present this idea in a way that points out the potential benefit to them. Also, clients should be given the message that the decision is up to them. Here are some examples of ways that this decision can be presented:

> *I know you're not sure about stopping pot smoking completely. Let's spend some time talking some more about what you want to decide. There are some good reasons to think about quitting pot completely. You mentioned a number of ways that pot is causing you problems, like the trouble with your parents and not thinking as clearly as you used to. By stopping pot use completely, you'll have the best chance of learning about how your life could be without pot. How does that sound to you?*
>
> or
>
> *As you think about what you want to do, I want to encourage you to consider stopping all drugs and alcohol, at least for a while. You'd get a chance to see what that's like so that you can decide what you want to do in the long run. It also gives you more of a chance to learn a lot about yourself—like what sort of things might have been keeping you smoking pot. What do you think?*
>
> or
>
> *If you think you might want to quit smoking weed at some point, this is a good time to try that out, while you have support from me and the other people in your group. What do you think?*

The key to the above interventions is allowing plenty of time to listen to the client's thoughts about the decision, responding with empathy, and avoiding argumentation.

Learning From a Slip or Relapse

A slip, or a full-blown relapse, should be viewed as a learning opportunity. Examine the events prior to the slip, and try to identify the trigger(s) and the clients' reactions to them. Were there expectations that marijuana use would change something or meet some need? What events followed the slip that might impact the likelihood of further use?

Help the client develop a plan to cope better with those antecedent events when they occur again, as well as with future cravings to use. Can any arrangements be made to reduce the likelihood of positive consequences of future use—or to make negative consequences more likely?

Urine Test Results

Urine specimens are taken at the fourth session, preferably before the session begins. It is only necessary that the test discriminate the presence or absence of drugs. In CYT, the urine screen tested for the presence of marijuana and alcohol. If a test is used that provides quantitative information and/or assesses the presence of additional drugs, this additional information should be handled along the same lines as the procedures discussed below.

The results of the urine test are discussed with clients at the beginning of the fifth session. Since this feedback is given in the context of a group therapy session, some clients may feel anxious about having this information shared. The therapist may let the group clients know that he or she has the results of their urine tests and could give them that feedback in the group. The therapist can also offer to convey the test results after the group meeting, if a client would rather hear them in private.

Using this method for feedback is recommended. If the group has been conducted in such a way that each client feels that it is safe to be honest, the great majority of clients are likely to choose to hear their urine test results in the group. This way, clients can receive feedback from other group members about their progress in this area. At the same time, by offering the option of hearing the results after group, this process is likely to proceed with a greater level of safety. Next, try to involve the whole group in a discussion about the test results, one specifically focused around ideas for coping in the future.

If the results for substance use are negative (i.e., drugs were not present), use these findings as an opportunity to provide strong positive reinforcement and support. For example, members may be encouraged to congratulate one another. Have group members who were able to abstain from substance use describe what they did to achieve that success. When applicable, encourage continued development of and involvement in activities that are incompatible with drug use, as well as association with persons who do not place the client at risk for drug use. Also ask about problems encountered during this period of abstinence, particularly problems frequently associated with drug use, such as emotional distress or cravings for specific drugs. Find out what the client did to cope with these problems and, if appropriate, assist him or her in identifying any problem-solving steps that he or she might have used to cope with high-risk situations (e.g., identified the existence of a problem, generated a list of possible solutions, and implemented one of them). Emphasize the importance of continuing to practice problem solving as one method of preventing relapse.

Clients whose urine test results were positive for one or more illicit drugs (i.e., drugs were present) should be asked to briefly review the circumstances and context of their drug use. This provides an opportunity to identify triggers and enhance coping. Inquire about potential external factors (persons, places, things) and internal factors (emotional distress, cravings) associated with recent use. Encourage both clients who used substances, as well as other group members, to think of other ways to cope with the identified trigger situations. Some group members who received positive urine results may indicate that they are not motivated to reduce or stop substance use and may indicate little motivation to learn alternative coping strategies. In such cases, respond using an MET style. For example, the therapist may make a brief empathic statement summarizing some aspects of that client's viewpoint:

It sounds as if you're saying that you're not disappointed that your test was positive for marijuana because, so far, you are not trying to stop smoking it. You have said that even though marijuana has caused some problems for you at your school, you enjoy getting high and you do not want to stop smoking at this time. If you decide to try to quit sometime in the future, hopefully you'll have gotten some helpful information from this group about how to do it.

The main point is that the therapist does not have to fight the client to become motivated or try to make the client feel badly that his or her urine tested positive.

Sometimes the client may deny recent use when the test results are positive. Therapists are advised to discuss such discrepancies in a collaborative manner, rather than through confrontation. The amount of time that it takes for a person's body to become free of tetrahydrocannabinol (THC), the active ingredient of cannabis that is assessed in the drug screen, varies. As a result, a positive drug screen does not allow the clinician to draw a clear conclusion about whether a client has used marijuana recently. When a client disagrees with a positive drug screen result, the therapist may tell the client that there can be a few different reasons for the discrepancy and that it may never be entirely clear which applies in this case. Tell the group that the following explanations have applied to other clients and seem possible in their case:

- The positive result may simply mean that previously reported use has still left physical traces that are showing up on the test. Emphasize that if clients continue to abstain from marijuana and other drugs, their drug test results will eventually be negative. Obviously this explanation is less likely to be plausible when a client reports many weeks of abstinence from marijuana (i.e., more than 4 to 6 weeks).

- For a number of reasons, clients may not believe that it is safe for them to be honest about recent use. Consider asking group members whether they relate to this, and try to briefly engage them in some discussion about why individuals may be reluctant to openly disclose their use. Approach the issue in an empathic MET style rather than an accusatory style. The idea is to recognize that a client may have been dishonest about recent use in a way that is likely to keep the dialog open. Even if the client in question does not become more open over time, it can be reassuring to the rest of the group to know that the therapist is not naive about the possibility of dishonesty.

- Consider mentioning that it may be possible that something has gone wrong with the test, but emphasize that this is an infrequent occurrence.

The main point in discussing these possibilities is to acknowledge the discrepancy between the test result and the client's report and to generate a productive dialog about possible reasons for that discrepancy and about the possibility of open disclosure in this setting. For clients who seem upset about a positive test result, the therapist may make some MET-style statements. For example:

> *It sounds as if getting a negative [drugs not present] test result is important to you.*
>
> or
>
> *How would getting negative [drugs not present] test results help you?*
>
> or
>
> *You see other group members getting negative drug test results; you want that for yourself, but you seem discouraged about being able to do that.*

In some treatment settings, clients are referred to treatment by legal authorities, and there may be a policy that urine test results are shared with the legal system. This kind of policy has a major influence on a client's reaction to his or her test results. When urine test results are to be shared with legal authorities, therapy proceeds best if this factor is recognized from the very first session, with the therapist reminding the client that the results of any urine test will be communicated to the legal system. The client needs to provide a related release of information. For all cases in which there is legal involvement (whether or not urine test results are to be communicated to the legal system), the therapist and client should review the various pros and cons of continued use versus abstinence together, and the therapist should make sure that the client takes his or her legal situation into account. Be explicit about this, as in this example:

> *You know that this program has agreed to communicate your drug test results to your juvenile justice worker, and you're thinking that your worker will recommend that you go to jail if you keep using. But even though you're pretty worried about that, you are saying that you might want to keep smoking weed and take that chance. Is that how you see it?*

The purpose of such statements is to help the client see that he or she is in charge of the decision and is responsible for its outcome. When such legal contingencies have been clear from the start, communicating positive urine test results is less likely to result in making the client extremely upset. A final recommendation regarding clients who may be legally mandated to treatment is to avoid the attitude—on the part of either the therapist or the client—that the legal problem is the only important influence on the client's motivation for change. No one wants to feel that someone else is forcing him or her to change, and any seemingly forced change is unlikely to endure. When faced with serious legal trouble, some clients stop using drugs and some continue to use. Clients are empowered when they are helped to appreciate that it is their own thought process that affects what they do in response to legal trouble.

The Safety Net

Because MET/CBT5 is a brief treatment involving the adolescent client individually, without ongoing family participation, procedures have been incorporated to monitor the client's progress or deterioration. This safety net is designed to capture clients for whom this treatment may be insufficient. At the start of treatment clients' parents or guardians are given a list of signs of clinical deterioration (a problematic decrease in various aspects of the client's functioning). They are made aware that, if the adolescent begins to show these signs, they should contact the therapist for assistance. In addition, the therapist should monitor each client's functioning for signs of clinical deterioration, including acute psychological disorder, markedly increased use of marijuana, and/or increased polysubstance use. If either the client's parent/guardian or the therapist notices signs of deterioration, the therapist should review this information with his or her clinical supervisor to determine what course of action should be taken.

Sometimes the client may benefit from continuing in the MET/CBT5 treatment with the addition of another intervention. Here are some general guidelines for planning a course of action. The therapist and supervisor should take the entire clinical picture into account in making a decision about a particular client. If only mild difficulties are observed, it may be appropriate simply to bring this information into the ongoing therapy and to actively monitor the client's progress. Some of these difficulties may decrease as the client makes progress in the MET/CBT5 therapy. When the client evidences symptoms of a possible comorbid psychiatric disorder of mild to moderate severity, a referral for psychiatric evaluation and possible treatment concurrent with MET/CBT5 treatment may be the most appropriate course. Finally, in the case of more severe deterioration involving a possible severe psychiatric disorder or a marked escalation of substance use, clients will likely require a transfer from MET/CBT5 to a higher level of care (e.g., inpatient, day treatment, residential, or intensive outpatient care).

Preparation for Individual Sessions

Prior to the first contact with a therapist, each client is seen for an initial assessment. In that meeting, the client provides background information regarding his or her life situation and marijuana problems. Data from this meeting are used to prepare a psychosocial report and the personalized feedback report (PFR), which is used in session 1. All the data that are needed for preparing the PFR can be obtained by completing the Global Appraisal of Individual Needs (GAIN) developed by Michael Dennis (1999). Appendix 4 shows the directions for using information from GAIN to compile the PFR. Please note that the PFR shown in the text consists of all possible items, but only a subset of those items are expected to have been endorsed by each client. Essentially, GAIN is used to determine which PFR items were endorsed by the client, and only those items are placed on that client's PFR. Two identical copies of the PFR are needed for session 1.

Here are some tips that may be useful in creating PFRs. PFR preparation can be made more efficient by creating a word processing file including the full PFR and then simply deleting the items that do not apply when each PFR is created. In addition, there are ways to save time in obtaining the necessary GAIN data. Some treatment settings may not have the time or resources to administer the full GAIN. When this is the case, a subset of the GAIN items may be prepared and administered, including all those necessary for preparing the PFR, as well as any others that are of particular clinical interest. An additional option is to obtain GAIN responses by using a self-report format, rather than through the GAIN interview format. Such a self-report format would need to be developed at the treatment site. If a self-report format is implemented, clients with limited reading and writing skills will need assistance.

Soon after the assessment interview is conducted and a therapist is assigned, the first session should be scheduled. Prior to the session, the therapist should review the psychosocial report and PFR. Reminder calls should be made to the client prior to each of the therapy sessions to confirm the appointment and increase the likelihood of attendance.

Overview of Two Initial (MET) Sessions

As described earlier, the first two therapy sessions are individual sessions focusing primarily on motivational enhancement. As described below, the first session is designed to allow the therapist to get to know the client and his or her unique situation, as well as to allow the client to begin learning what he or she can expect from treatment. Another task of the first session is to provide the client with individual feedback about his or her marijuana problem, accompanied by interventions aimed at increasing motivation for change.

The second session, to be scheduled approximately 1 week after the first, continues the process of developing motivation for change. Specifically, progress since the first session is reviewed, and an overall goal for treatment is developed in a collaborative process involving therapist and client. The final parts of this session prepare the client for the remainder of treatment: (1) the introduction of the key concept of functional analysis and (2) orientation to the group sessions.

Session 1: MET1—Motivation-Building Session

Key Points:

- Build rapport with the client.
- Familiarize the client with what he or she can expect from treatment.
- Begin the process of assessing and building the client's motivation to address his or her marijuana problem.
- Review the personal feedback report with the client.

Delivery Method: MET-focused individual therapy

Session Phases and Times:

1. Rapport-building and orientation to treatment (20 minutes)
2. Review of PFR and reactions to it (30 minutes)
3. Summarization of today's session and preparation for next session (10 minutes)

Time: 1 hour total

Handouts:

- Two copies of the client's personalized feedback report
- A *Guide to Quitting Marijuana* brochure
- An orientation sheet entitled Welcome!

Materials:

- A pocket folder

Procedural Steps

Phase 1: Building Rapport. This is an extremely important part of the treatment, during which the therapist and client first get to know each other. The goal is to create the feeling that the therapy sessions will be safe and supportive.

The therapist should begin by introducing himself or herself and then briefly explain the purpose of the first meeting—i.e., to become acquainted with the client and to give the client some information and feedback. The therapist may indicate that he or she has learned a bit about the client from information obtained during the intake or referral process or from the research staff but finds it most helpful to hear it directly from the client.

Here is the suggested discussion sequence for the rapport-building phase of the session:

1. Start with some casual conversation and a review of demographic facts, and attempt to learn a bit more about the client. For example, you can talk about whether the client is in school and, if so, in what grade; his or her living situation (where and with whom); and whether he or she has a job. This discussion should be fairly general and brief in order to leave enough time for the remainder of the session.

2. Ask an open-ended question about what led to the client's involvement in marijuana treatment, as this will most likely present opportunities to initiate some of the MET strategies described earlier in this treatment manual. Try to include discussion about the following:

    - How the marijuana use first started
    - The extent of recent use
    - Whether there have been any previous attempts at quitting
    - What the client hopes to gain from treatment.

Phase 2: Orientation to Treatment. Give the client a copy of the Welcome! orientation sheet, which introduces the client to the treatment, and summarize the main points. You do not need to read it word for word.

Give the client the *Guide to Quitting Marijuana* brochure, and encourage the client to read the brochure before the next session. The *Guide to Quitting Marijuana* was produced by the Drug and Alcohol Research Centre, Sydney, Australia, and is available from Lighthouse Publications at:

702 W. Chestnut Street
Bloomington, IL 61701
Telephone: 888-547-8271
Voice: 309-829-1058, x 3414
Fax: 309-829-4661
Web site: www.chestnut.org/li/publications
E-mail: cschwartz@chestnut.org

Ask the client to bring the folder to each session because you will be providing additional information to add to it.

Welcome!

What You Can Expect From Us

Help for your marijuana problem. Treatment consisting of five sessions, covering a 5 to 8 week period. First you'll have two individual sessions, then three group sessions. The sessions are designed to give you support and information about coping and to help you with marijuana-related problems. In the group sessions, you'll get a chance to practice some coping skills and get feedback from other program clients.

Effective treatment. Delivered by a competent therapist. Your therapist is ________________________________.

Confidential treatment. What you tell us in treatment is confidential, meaning that we cannot tell anyone what you said without your permission, with the exception of those people described on the consent form. However, if you tell us that you are going to harm yourself or another person, or tell us about child abuse or neglect, we are required by law to inform those who can obtain help for you or for others.

What We Ask From You

Attendance. We ask that you come ***on time*** to all of your scheduled appointments. If you must cancel, we ask that you call the treatment program number (_____-_______) so that your therapist can be notified ahead of time and can call you to reschedule.

A clear head. We ask that you not use any drugs or alcohol on days when you have an appointment with your therapist. We believe that you will be able to benefit most from this program if you are not under the influence during your sessions.

Completion of treatment. We hope that you will come to all of your scheduled sessions. If, however, you ever consider leaving treatment early, we ask that you discuss this with your therapist as soon as possible.

Review of the Personalized Feedback Report

The therapist should give the client a copy of his or her PFR and lead the client through a systematic review of it. The therapist and the client should have their own copies of the PFR to review together to increase the collaborative nature of this process. The PFR included in this manual illustrates all possible items that could appear on a PFR. The client's PFR will include some subset of the illustrated items, based on the client's responses during the intake or research assessment.

The PFR is most useful for developing motivation when the client is given the opportunity to elaborate on each point. For example, as the therapist and client are reviewing the problem list section of the PFR, the therapist might say:

> *I know you've already told me some of the problems marijuana has been causing in your life [during the rapport-building phase of the session]. As we go over this list, why don't you tell me some more about each of these problems, like the first problem: In what ways has marijuana led to 'missing work or classes'?*

The main task for the therapist is to listen to the client and respond with empathic reflection. Remember that the purpose of the PFR is not to do an initial assessment: The client already provided much information about his or her background and demographics in the initial assessment. If the therapist finds that the focus shifts to asking questions for which the solicited response is basic information, the PFR review is not serving the intended purpose. Instead, the therapist needs to focus on the MET processes described earlier (i.e., expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy). The PFR provides the raw material for engaging in a discussion that employs these techniques. If this therapy session is performed as intended, the therapist is likely to find that by the end of the session, he or she has a general picture of the client's current life situation and a real understanding of the client's thoughts and feelings about making a change in his or her marijuana use.

Sometimes clients may respond to the PFR review by attempting to argue about the validity of the items on their personal report (e.g., "I didn't say smoking pot was causing me money problems!"). In such cases, do not try to debate the client with replies such as, "You must have checked off something like that, or it wouldn't be on the report!" or "Well, you must pay for the pot in some way!" Instead, maintain a nondefensive tone, acknowledge that the client knows best what areas of his or her life have and have not been affected by marijuana use, and move on to the next item.

In keeping with the general recommendations for using this therapy, therapists again are encouraged to use open-ended questions rather than closed-ended questions. For example, "Did you say you used marijuana in unsafe situations?" is a closed-ended question that invites the potential to disagree with the PFR item. Saying "Tell me about using in unsafe situations" invites elaboration and discussion.

Therapists may find that some sections of the PFR are especially conducive to motivational interviewing. For example, with a number of clients, the problems and the reasons for quitting sections may be especially likely to induce the client to explore his or her ambivalence about smoking marijuana. Therapists may adjust the relative emphasis on sections of the PFR to accentuate those sections that produce constructive discussion for any given client. For example, if a client seems especially interested in describing his or her reasons for quitting, the therapist may choose to spend extra time focusing on that area.

Note that the PFR review is expected to take approximately 30 minutes. This allows for quite a bit of discussion and related comments. Use double-sided reflections, develop discrepancy, and employ other MET strategies where relevant. Reviewing the PFR provides an excellent opportunity to explore the client's ambivalence and to begin developing motivation for change. After reviewing the entire PFR, ask the client about his or her reactions to it, and listen with empathy.

Phase 3: Session Summary. In the final portion of the session, summarize the main points that you heard the client saying. Ask the client about his or her current readiness for change. Some clients are ready to verbalize the goal to change at this point. However, if a particular adolescent is not feeling ready to set a goal for change, the therapist should not pressure the client into doing so.

The following recommendations apply to helping those clients who do verbalize the goal to change:

If the client says that he or she wants to quit or reduce his or her marijuana smoking, ask what might help him or her to achieve that goal. Many clients may spontaneously come up with some ideas, such as asking friends to help them or not buying any more marijuana. Reinforce any such statements. If they are unable to come up with any ideas, help them do so. For example, say that some people find it helpful to stay away from friends who use, and ask if they think this would be helpful for them. Some of these ideas may flow directly out of the PFR discussion. Help them develop a plan regarding any remaining marijuana they have. Some clients may say that they are going to finish smoking the marijuana that they have left in their possession, while others may be comfortable disposing of it (giving it away, flushing it, etc.).

Many clients may not yet be willing to make a commitment to abstinence. Whether the client plans to quit or reduce use at this point, tell him or her that you'll continue discussing this issue during the next session. Ask the client what today's session has been like for him or her. Set up an appointment to meet again next week, and write it down on an appointment card.

This example of the PFR contains every possible PFR item. The PFR for any given client will contain only the items that the client endorsed during the initial assessment.

Therapist ____________________
Client ____________________

Personalized Feedback Report (PFR)

This report summarizes some of the information that you gave us in your interview on ___/___/____.

We want to give you an opportunity to review what you've told us and make any changes or additions. As you and I work together in reviewing and discussing this specific personal information, we can help you develop a program and strategies for dealing with marijuana that fit your individual needs.

Primary Substances

You reported that your favorite substance to use was__________________ and that you needed treatment for ____________________________. You told us you first used alcohol or drugs at age ____ and have been smoking marijuana for ____ years. In the past year, you told us you had used __________________. You have been in substance treatment ____ times before.

Extent of Use

In the past 90 days, you smoked marijuana on _____ of those days, with most being ____ hits over a ___hour period. This places you in the _____ percentile relative to other adolescents age ___ to ___ in America.

In the past 90 days, you drank alcohol on _____ of those days, with the heaviest drinking episode being ____ drinks over a ___ hour period. This places you in the _____ percentile relative to other adolescents ages ___ to ___ in America.

In the past 90 days, you reported that you used other drugs, including ____________________, on ___ days. In the past week you reported that you (had/had not) tried to quit (and that when you did you had the following problems: ____). [List could include moving and talking much slower than usual; yawning more than usual; feeling tired; having bad dreams that seem real; having trouble sleeping (sleeping too much or trouble staying asleep); feeling sad, tense, or angry; feeling really nervous or tense; fidgeting, wringing your hands, or trouble sitting still; having shaky hands; having convulsions or seizures; feeling hungrier than usual; throwing up or feeling like throwing up; having diarrhea; having muscle aches; having a runny nose or eyes watering more than usual; sweating more than usual; having your heart race or goose bumps; having a fever; seeing, feeling, or hearing things that are not real;

forgetting a list of things or having problems remembering; having withdrawal symptoms that prevented you from doing usual activities; starting to use again to avoid withdrawal symptoms, other: ____________________ .]

Problems

You indicated that your use of marijuana, alcohol, and/or other substances had caused you the following kinds of problems:

- You did not meet your responsibilities at home, school, or work.
- You used in situations where it was unsafe for you.
- Using caused you to have repeated problems with the law.
- You kept using even though it was causing you to get into fights.
- You had to use more to get the same high.
- You had withdrawal symptoms when you tried to stop.
- You used for longer than you wanted to.
- You have been unable to cut down or stop using.
- You spent a lot of time getting or using marijuana, alcohol, or other substances.
- Using led you to give up activities or caused problems at home, school, or work.
- You have kept using despite medical or psychological problems.

As you reflect on the consequences to your life of smoking marijuana, what would you add?____

____

____

Reasons for Quitting

You said the main reason you came to treatment was____________________ ________________________. We showed you a list of personal reasons for quitting marijuana, and you said that you wanted to quit:

- To show myself that I can quit if I really want to.
- To like myself better.
- So that I won't have to leave social functions or other people's houses.
- To feel in control of my life.
- So that my parents, girlfriend, boyfriend, or another person I am close to will stop nagging me.
- To get praise from people I am close to.
- Because smoking marijuana does not fit in with my self-image.
- Because smoking marijuana is less "cool" or socially acceptable.
- Because someone has given me an ultimatum.
- So that I will receive a special gift.
- Because of potential health problems.
- Because people I am close to will be upset if I don't.
- So that I can get more things done during the day.
- Because my marijuana use is hurting my health.
- Because I will save money by quitting.

- To prove I'm not addicted.
- Because there is a drug testing policy in detention, probation, parole, or school.
- Because I know others with health problems caused by marijuana.
- Because I am concerned that smoking marijuana will shorten my life.
- Because of legal problems related to my use.
- Because I don't want to embarrass my family.
- So that I will have more energy.
- So my hair and clothes won't smell like marijuana.
- So I won't burn holes in clothes or furniture.
- Because my memory will improve.
- So that I will be able to think more clearly.

You listed these because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?

____

____

You also told us about several other problems that might be caused or made worse by your marijuana, alcohol, or other drug use. These include:

- The health problems you reported.
- The emotional problems you reported.
- Being bothered by upsetting memories.
- Having problems paying attention or controlling your behavior.
- The family problems you reported.
- Arguments, and problems you had with your temper.
- Being physically, sexually, or emotionally hurt.
- Doing things that were illegal.
- Getting in trouble at school.
- Getting in trouble at work.

Pattern of Use

You told us that the place(s) where you typically use marijuana, alcohol, and other drugs is/are:

- At home
- At someone else's home
- At a party/bar
- At work
- At school
- At a dealer's house
- Outdoors
- In a car
- Somewhere else (__________________________________)

and that you typically use it with:

- No one else, alone
- Your romantic/sexual partner
- Family
- Friends
- A club or gang
- Coworkers
- Classmates
- A running partner (someone you regularly do drugs with)
- A drug dealer/pusher
- Someone else (________________________________)

As you think about highly tempting situations, are there situations that you'd like to add? ____________________________________
____

Situational Confidence

You told us that you thought you could avoid using alcohol or drugs:

- At home
- At school or work
- With your friends
- When everyone around you was using them

You also told us that you (had quit and were ______% sure you could stay abstinent/you had not quit yet but were ______% sure you could quit).

Session 2: MET2—Goal-Setting Session

Key Points:

- Review progress, thoughts, and reactions since session 1.
- Collaborate on setting a treatment goal or goals for the remaining treatment sessions.
- Introduce the concept of functional analysis.
- Prepare for the group therapy sessions.

Delivery Method: MET-focused individual therapy

Session Phases and Times:

1. Review of progress (15 minutes)
2. Goal-setting (20 minutes)
3. Functional analysis (20 minutes)
4. Preparation for group (5 minutes)

Time: 1 hour total

Handouts:

- A personal goal worksheet
- Blank personal awareness worksheets for functional analysis (entitled Knowledge Is Power)
- A group preparation sheet titled Information and Expectations: Group Sessions

Procedural Steps

Begin by greeting the client. Notice if the client has brought back the folder of information. If so, state that you are glad to see that; if not, encourage the client to bring it next time.

Phase 1: Review of Progress. Begin the review of treatment progress by asking the client how he or she has been doing over the past week regarding the marijuana issue. The therapist should be prepared to listen for possible changes in the client's behaviors, thoughts, and feelings regarding marijuana. Before asking a lot of questions, let the client tell you how he or she has been doing regarding his or her marijuana use or abstinence first. Respond with reflective comments, and attempt to elicit the client's own motivation-enhancing statements. In order to get a fuller picture of the client's marijuana-related behaviors, thoughts, and feelings, you may want to ask questions. Your questions may center on:

Behaviors related to marijuana:

- *How much did you smoke over the past week, if at all?*
- *What was going on at the time you smoked (or felt like smoking)?*
- *Have you told any of your friends about your plans to stop smoking?*
- *Did you read the* Guide to Quitting Marijuana *brochure? What are your reactions to that?*

Thoughts about marijuana:

- *It sounds like you've given this issue a lot of thought. Tell me more about what you're thinking regarding pot smoking at this point.*
- *What thoughts have you had about that PFR we went over last time?*

Feelings about marijuana:

- *How did you feel after you smoked?*
- *It sounds like you have mixed feelings about whether or not you want to quit. Tell me some more about that.*

As you listen to the client, be prepared to express empathy, provide double-sided reflections as appropriate, reinforce client efficacy, and roll with resistance. After approximately 15 minutes of opening discussion, move into the goal-setting phase of the session.

Phase 2: Goal-Setting. Up to this point, you may have been hearing the client make statements indicating some motivation for change. If so, summarize this; if not, try to accurately reflect the client's feeling that he or she is not yet ready to commit to change.

Either way, explain to the client that having a written goal increases the likelihood that the rest of the therapy will be meaningful and/or useful to him or her, and that he or she will be more likely to succeed. When working with clients who say they are not willing to give up marijuana, let them know that other goals may be useful to them. For example, some may decide to start by trying to reduce their marijuana smoking. Others may simply like to set the goal of learning more about the skills for quitting or reducing marijuana use.

Give the client a copy of the personal goal worksheet and a pen so that he or she can fill it out in the session. It is a good idea to have clients verbalize each section of the goal worksheet before writing it down. This way, the therapist can offer feedback and suggest modifications before ink is put to paper, in such a way that the client is less likely to feel criticized. If the goal is vague, insufficient, or inappropriate, engage the client in a collaborative process to revise it. Offer to help clients with ideas if they get stuck. Many clients may be able to come up with some good ideas for steps they can take to achieve their goal. If they have trouble with this, here are some ways to help them:

- Tell them that many people find they can be more successful at stopping/reducing use by staying away from substance-abuse opportunities, and encourage them to write down ways they could reduce such situations in their lives.
- Ask them about ways that they could distract themselves by doing something else instead.
- Let them know that they will be learning more about specific strategies for addressing marijuana-related problems in the next three sessions.

When the personal goal worksheet is complete, be sure to have the client sign and date it. Ask the client to read it to you, even though you may have already heard all the parts of the goal worksheet in progress. You can explain to the client that reading it aloud helps reinforce the client's motivation to achieve the goal. Ask permission to make a photocopy of the worksheet at the end of the session. Return the original to the client, and place the copy in the chart.

Personal Goal Worksheet

This is my goal regarding my marijuana use:

____

____

Here are some important reasons for my goal:

____

____

____

The steps I plan to take to achieve my goal are:

____

____

____

____

____________________________ Name   ________ Date

Phase 3: Functional Analysis. After having participated in the previous portions of the therapy aimed at improving motivation and beginning to resolve ambivalence, clients should now be ready to examine the function of marijuana in their lives. Actually, the groundwork for this has been laid. This exercise is included at this point to help clients understand that marijuana use doesn't just happen but is rather a function of antecedents and consequences. The aim is to increase clients' awareness of those factors, to provide better focus for the ensuing CBT interventions, and to enable better decision making on a daily basis.

To convey the concept of functional analysis, the therapist may begin with a social learning explanation of marijuana abuse. As the therapist goes through this explanation, he or she may draw on what the client has already described to illustrate the various points. The therapist should try to explain the concept in simple language, using concepts that the client can understand. Here is an example of such an explanation:

> *I want to explain to you how we think about marijuana problems. When someone has a marijuana problem, we think of it as a negative habit, similar to other habits like biting your nails or eating junk food. We try to help the person figure out what has been keeping the habit going. This way, if someone wants to stop the habit and knows what is keeping it going, he or she can use this information to help stop it. Does thinking of it as a habit make sense to you?* [Discuss]
>
> *After a while, if someone has often gotten high in certain situations, just being in those situations can make that person feel like getting high. We call that a trigger. It could be anything about the situation like the time of day, whom you're with, or even something like a type of music. You have mentioned some things that sound like triggers for you. What do you think some of your triggers are?* [Discuss]
>
> *Another type of trigger can be how someone is feeling. Some people say that they feel more like smoking marijuana when they are feeling badly—like feeling bored, nervous, or angry. They say that smoking is a way of trying to cope with the bad feelings. Some people especially feel like smoking marijuana when they are happy or excited. Does this part of it—someone using to affect how they feel—make sense to you?* [Discuss]
>
> *Sometimes people develop certain thoughts or ideas about their use, like 'My friends will think I'm boring if I don't take a few hits,' or 'I'll just smoke this one time,' or other ideas. These thoughts and ideas affect whether or not somebody uses.*
>
> *The point is that marijuana use doesn't just suddenly happen. Usually there are things going on around a person or in the way someone is thinking or feeling that affect whether or not he or she smokes marijuana. Knowing what affects your own use gives you more power to decide whether or not to use. And looking at both the pros and cons of what happens after you use also helps you understand*

why you use and helps you make decisions about what you want to do in the future. That is why we call this sheet Knowledge Is Power. [Give them a blank copy of it; keep one for yourself.] *Figuring out the factors that lead to your own marijuana use gives you more power to decide what to do next, and to break the habit, if you want to. That's the main thing that we are trying to do in this program—to give you a lot of different ways to take back control instead of being under the control of the habit.*

Having given a rationale for treatment, the therapist should involve the client in a functional analysis of his or her own use. The discussion can focus on a recent episode(s) of use that the client has reported, or it could focus on the client's use in general. The therapist should fill in some of the client's responses on the personal awareness form while the client follows along with a blank copy of his or her own. Here are some ideas for discussing the subsections (from row one) of the worksheet:

Trigger:

What sorts of things are often going on when you decide to smoke marijuana?

This may include places, people, activities, specific times or days, and other situational aspects of use.

Thoughts and Feelings:

Can you remember your thoughts and feelings the last time you used?

Adolescents may be less likely than some adults to be able to identify and label their feelings. It may help for the therapist to offer some examples of how some adolescents say they have felt before they decided to use (e.g., bored, angry, excited, sad). Also, some adolescents may have trouble identifying their thoughts. The therapist may be able to elicit their thoughts better by asking clients what they were saying to themselves at the time.

Behavior:

Write down what happened at a recent time that these triggers were experienced.

Often, in the example reviewed in the session, the client will have smoked marijuana (possibly along with other substance use, which should also be recorded). However, let the client know that this analysis can also apply to situations in which the client chose not to use.

Positive Results:

> Some clients, when asked what good things resulted from use, may try to please the therapist by saying nothing; however this may not provide the full picture of a client's use. The therapist may elicit a fuller response by saying something along these lines:
>
> *There have probably been some things that you have liked about using, or you wouldn't have kept doing it.*

Negative Results:

> Ask the client what negative results followed his or her marijuana use. If the client has trouble coming up with some of these answers, the therapist may prompt him or her by asking about some of the areas covered on the PFR problem list, as well as other problems the client has mentioned thus far. For example, the therapist may ask the client whether the use had any effect on family relationships.

Show the client how you have recorded his or her responses on the personal awareness form, and ask for his or her reactions and questions. The therapist should make a photocopy of this example for the client's chart. The original and an additional blank form both are given to the client, who is asked to use them to record other episodes of use or craving that occur before the next session and to bring these forms to the next session.

Knowledge Is Power

Personal Awareness: What Happens Before and After I Use Marijuana?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE RESULTS	NEGATIVE RESULTS
(What sets me up to be more likely to use marijuana?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Adapted from Jaffe et al., 1988

Sample Knowledge Is Power Form

Here is an example of how the self-monitoring record may look after the therapist has helped the client complete it while reviewing a recent episode of use:

Personal Awareness: What Happens Before and After I Use Marijuana?

TRIGGER	THOUGHTS AND FEELINGS	BEHAVIOR	POSITIVE RESULTS	NEGATIVE RESULTS
(What sets me up to be more likely to use marijuana?)	(What was I thinking? What was I feeling? What did I tell myself?)	(What did I do then?)	(What good things happened?)	(What bad things happened?)
Friend called and invited me to smoke with him. Nothing else to do.	"I want to reward myself." "I'm bored." "Felt good about going 15 days w/o smoking, so felt OK about smoking today."	Went out with friend and smoked.	Had fun. Felt good to get high, having gone 15 days without.	Broke the 15-day abstinence (although wasn't too worried about this). Didn't get as much done. Didn't feel as healthy.

Phase 4: Preparation for Group. Remind the client that, as explained when he or she enrolled in the program, the next three sessions are done in a group. The group meetings will be 75 minutes long. Provide an idea of how many other clients will be in the group, how many males, how many females, and where it will take place. Describe the general format for each group session:

- Review of marijuana-related problems that occurred in the past week
- Discussion of new coping skills and how they relate to client's problems
- Practice of new coping skills in the group
- Development of plans to practice the new coping skills at home.

Next, review the "Information and Expectations: Group Sessions" sheet with the client. After discussing it, the client and therapist should sign it. Ask the client what else he or she would like to know about the group, and also how he or she feels about the upcoming group sessions.

Clients may express some anxiety about the group sessions. If so, reassure them that this feeling of anxiety is normal and is likely to subside as they get involved in the group. Remind them that other clients may be feeling a similar nervousness. If a client is particularly nervous, help him or her think of ways to feel calmer (e.g., sitting next to the therapist, taking some deep breaths, telling themselves that it will be okay).

Tell clients that they are likely to find that the members of the group will be at different points regarding their motivation and readiness for change. If a client has expressed a good deal of motivation for change, talk about ways he or she may preserve that feeling when faced with others who may not be motivated for change. If the client feels negatively about change, ask how he or she feels about being in a group where some of the other clients may be more actively working on quitting. You may point out the benefit of staying open to a variety of perspectives. Also let the client know that while it will be acceptable to talk about his or her mixed feelings (including positive feelings about what the client feels marijuana does for him or her), he or she will need to be careful not to talk about it in a way that may trigger other members who are trying to quit. Let clients know that, regardless of each client's readiness for change, all perspectives are to be treated with respect. Review the group rules for the upcoming sessions. Give the client an appointment card with the date and time for the upcoming group session written on it.

Remember to photocopy the personal goal worksheet and the personal-awareness sheet. Conclude the session.

Information and Expectations: Group Sessions

Group sessions will last 75 minutes. Please arrive on time and attend all group meetings.

If you cannot attend a group meeting, please call ____________ at ________________ ahead of time. If you miss a group session, you will be asked to make it up before or after the next session.

Your active participation is important to the whole group. All group members are asked to listen to one another without interrupting, to respect the opinions of others, and to offer feedback to other group members.

Each group member's confidentiality is to be respected. What is said in group stays in group; please do not discuss what is said in group.

In order to make the group a safe place with a positive focus, the following behaviors are not allowed in group:

- Coming to group under the influence
- Threatening remarks or gestures
- Excessive profanity
- Wearing gang-related clothing
- Sexually inappropriate comments, gestures, or clothing
- "War stories," bragging about drug and alcohol use
- Exclusive relationships

The above behaviors could result in a client being asked to leave the group.

I have read this information sheet, and I agree to comply with the expectations for positive participation in group.

______________________________	________________
client	date
______________________________	________________
therapist	date

VI. Cognitive Behavioral Therapy

The next three sessions of MET/CBT5 primarily employ cognitive behavioral therapy, an approach that focuses on understanding a person's behavior in the context of his or her environment, thoughts, and feelings. The foundation for the cognitive behavioral group sessions has already been established in the introduction to functional analysis section in session 2. Another key tenet of cognitive behavior therapy is that individuals manifesting maladaptive behaviors may be able to learn coping skills that would allow them to decrease or abstain from the negative behaviors. Thus each of the group sessions focuses on teaching clients a particular skill designed to help them abstain from marijuana and other substance use. The following section provides some recommendations for carrying out the cognitive behavioral group therapy sessions, which are applicable to all the remaining sessions. This section draws heavily on the book *Treating Alcohol Dependence: A Coping Skills Training Guide* (Monti et al., 1989).

Key Concepts and Session Guidelines

The particular cognitive behavioral treatment approach specified in this manual is based on a social learning model, with a focus on training people in interpersonal and self-management skills. The primary goal of this treatment is for clients to master the skills needed to maintain long-term abstinence from marijuana. An important element in developing these skills is identification of high-risk situations that may increase the likelihood of relapse. These high-risk situations include external precipitants of using, as well as internal events such as cognitions and emotions.

Having identified situations that may create a high risk for relapse, clients must develop skills to cope with them. In the three CBT group sessions, clients are taught basic skill elements for dealing with common high-risk problem areas and are encouraged to engage in roleplaying and real life practice exercises that will enable them to apply these skills to meet their own needs.

Clients must get a chance to build their skills by receiving constructive feedback using relevant (client-centered) problems. Active practice with positive, corrective feedback is the most effective way to modify self-efficacy expectations and create long-lasting behavior change.

Cognitive behavioral treatment for marijuana abuse requires the client's active participation, as well as his or her assumption of responsibility for using the new self-control skills to prevent future abuse. Through active participation in a training program in which new skills and cognitive strategies are acquired, an individual's maladaptive habits can be replaced with healthy behaviors regulated by cognitive processes involving awareness and responsible planning. Marlatt and Gordon (1985, p. 12) state:

As the individual undergoes a process of deconditioning, cognitive restructuring, and skills acquisition, he or she can begin to accept greater responsibility for changing the behavior. This is the essence of the self-control or self-management approach: one can learn how to escape from the clutches of the vicious cycle of addiction, regardless of how the habit pattern was originally acquired.

Since behavioral approaches to treatment could be applied inappropriately—without careful consideration of the unique needs of the individual receiving treatment—it is important that therapists be experienced in psychotherapy skills as well as behavioral principles. They must have good interpersonal skills and be familiar with the materials in order to impart skills successfully and serve as credible models. They must be willing to play a very active role in this type of directive therapy.

Prior to each treatment session, therapists are encouraged to reread relevant sections of the manual. To ensure that the main points of each session are covered, we recommend making an outline of them or highlighting them in the text. In presenting the didactic material, we suggest briefly paraphrasing the main points and listing them on a blackboard.

When implementing a therapy based on a manual, it is essential that clinicians do not read the text verbatim. As long as the major points are covered, a natural, free-flowing presentation style is preferred. It is crucial for the clients to think that their treatment issues and concerns are more important than the therapists' agenda of adhering strictly to the manual.

Indeed, if clients are not routinely involved and encouraged to provide their own material as examples, we have found that treatment becomes boring and the energy level for learning drops off dramatically. Therapists may experience burnout as a result. Effective reinforcement of clients' active participation can help prevent burnout on the part of both clients and therapists.

The topics covered in each session are intended to teach skills that are highly relevant to the problems in clients' daily lives. To help clients view treatment as relevant to their daily lives, it is essential that a therapist strive as much as possible to provide examples from material that the clients have previously brought up. Usually this is not difficult, because the skills training sessions cover commonly encountered problems that are likely to have been raised already by the client.

Transitioning From Individual to Group Sessions

In MET/CBT5, therapists transition from working with clients on an individual basis to seeing them as a part of a group. Here are some guidelines for navigating questions of confidentiality and working alliances, which may occur in making this transition. Some therapists may be familiar with this process, having seen clients individually for an initial assessment and then treating them in group therapy. Therapists may question how to handle issues of confidentiality, given that by the time they see clients in the CBT group sessions, they will have quite a bit of personal information about each client. This concern is a particularly sensitive one with adolescents, who are especially concerned about how they are seen by their peers. The idea is to utilize that information while at the same time respecting clients' confidentiality. A good way to do that is to refer to the general topic and invite clients to share their personal information. For example, if one group member is talking about legal problems associated with his or her substance use, the therapist may say, "There are other people in the group facing this problem. Would anyone else like to say what that's been like for you?"

In this example, the therapist does not identify any specific group member as being in legal trouble. The therapist can also further broaden the discussion by saying, "Or even if you haven't been arrested, you might be worried about possible trouble with the law. Do you relate to this?"

The therapist may also invite a particular client to share personal information by referring to the topic in a way that does not reveal sensitive information. For example, "Joe, this reminds me of your situation. Would you be comfortable telling the group about what's going on with you and your parents?"

If "Joe" declines to do so, don't pressure him. He may decide to when he feels more comfortable. Of course there is always the risk that "Joe" may be upset even about having the therapist reveal that his situation is similar. In such a case, the therapist is encouraged to apologize without becoming defensive.

The flip side of this issue is that a client may make reference to something he or she and the therapist have discussed, in a way that excludes the rest of the group. When this occurs, the therapist should ask the client to fill the group members in on the story. Here is an example:

> **Lisa:** [looking at the therapist] *Remember that problem I was having with my friend Jane? Well I talked to her, and she said. . . .*
>
> **Therapist:** *Hold on a second. Could you fill the group in on what was going on?*

In general, the therapist acknowledges and makes use of information acquired in the individual sessions, but he or she puts the adolescent in charge of sharing, or not sharing, that information with the group.

In working with adolescents, some therapists have noticed that clients may verbalize their motivation to quit marijuana in the individual sessions and then seem less motivated in the ensuing group sessions. In some cases, the therapist may suspect that this shift is due to the adolescent's concern that the other group members may not think he or she is cool. The therapist may feel disappointed or frustrated by the client's seeming lack of cooperation and may feel like confronting the client on this change. Doing so, however, is only likely to cause the client to feel ashamed and, perhaps, intensify his or her antiabstinence position. The following strategies are likely to be more productive.

If the therapist perceives that, overall, the group is communicating the attitude that "using is cool, quitting is not cool," the therapist can state what he or she observes. Sometimes the group members may acknowledge this position, which may result in some productive dialog about pressures clients may face in their relationships outside of group. Even if the group rejects the therapist's observation, just having stated it may decrease the likelihood of continued antiabstinence communications.

Another strategy is to acknowledge that a number of group clients may have similar mixed feelings about quitting versus continuing use. The therapist may employ some double-sided reflections that speak to the group as a whole. For example, the therapist could say:

> *Even though each of you came to this program because of some problems related to your marijuana use, a number of people are saying that you have a lot of good memories about times you've smoked, and you're not sure that you want to give it up now.*

Obviously, if the group wanted to focus at length on memories of being high, the therapist would need to set limits to avoid romanticizing marijuana use or triggering cravings.

Discussion of Clients' Recent Problems

[The following recommendations are from the Monti et al. (1989) coping skills training guide for treating alcohol dependence.]

Clients experience numerous problems, cravings, and actual slips as they struggle with abstinence. Although the focus of the sessions must be on the structured program, ignoring clients' real life problems entails the risk that they will view treatment as peripheral or irrelevant to their current needs. As a compromise between the demands of the protocol and clients' perceived needs, approximately 15 minutes should be spent at the outset of each session discussing clients' current problems related to marijuana.

Make efforts to structure these discussions along lines that are consistent with a skills-training approach by using a problem-solving format that involves clearly specifying the problem, brainstorming possible ways of dealing with it, and selecting one way to try out in the situation. The rule is that the opening discussions should be structured along behavioral lines to keep them consistent with the approach of this manual.

If necessary, clearly state to the clients that while skills treatment can help them practice new ways of coping with problems, these problems cannot always be fully discussed to the point of complete resolution. Long-term resolution of specific problems may require additional work after this program is finished.

If serious problems arise repeatedly, consult with your supervisor. It may become necessary to initiate alternative treatment.

Presentation of Skill Guidelines

In each of the cognitive behavioral group sessions, the focus is on teaching a particular skill: (1) marijuana refusal skills, (2) enhancing the social support network, and (3) coping with relapses. Posters focusing on the skill to be taught in each of the sessions are included in appendix 3 of this manual. The poster corresponding to the current session should be hung in the group room where everyone can read it. Only the poster relating to the current session should be displayed, so that the material presented will be novel and, thus, more likely to capture group members' attention.

In presenting a particular skill, therapists should start by providing a rationale for learning that skill. The main points of the therapeutic rationale are covered on the "why?" part of the poster and will become more meaningful to clients if therapists draw parallels between the rationale and events in group members' lives. For example, therapists leading session 3 may ask group members if they have noticed a narrowing of their own social circles to include primarily other drug and alcohol users. In describing the session 5 rationale that relapse is an opportunity for learning, a therapist may refer to a relapse story that a client shared earlier in the group and encourage the client and the rest of the group to identify what could be learned from that experience.

Next, therapists review the skill guidelines shown on the posters. Here, again, the key to engaging the group is to make these guidelines come alive by illustrating them with examples and explicitly stating how they are relevant to clients' lives. Therapists may also engage clients by having them take turns reading the skill guidelines out loud. Be aware that some clients may have deficits in their reading skills or may be uncomfortable reading aloud in group. Provide them the opportunity to bow out gracefully. For example, you may tell group members that they can just say "pass" if they prefer not to read.

Therapists may be able to make the skill guidelines fun and interesting by using some creativity. For example, the therapist may demonstrate the contrast between making a refusal statement in a voice that is clear and firm rather than vague and hesitant. One group member, for example, might like to try demonstrating the contrast between refusing marijuana with and without making eye contact. In covering the material included for each session, therapists are encouraged to make it lively and fresh. This can be accomplished while staying true to the protocol. Encourage questions and comments about the skill guidelines. If a group member says that a particular skill is not useful, don't be defensive—instead, focus on listening to the client's concerns. As in the individual MET sessions, group clients may be more open to the therapist's input if they do not feel that the therapist is trying to convince them.

Emphasize the importance of real life practice of the skills, as well as practice within the group through roleplaying. The following section contains some guidelines for using roleplay with clients and is based on Monti and colleagues' (1989) coping skills training guide.

Guidelines for Behavior Rehearsal Roleplay

The main factor that determines the success of cognitive behavioral skills training is the extent to which clients practice and apply the new skills in their lives. Roleplays in the group therapy sessions give clients a chance to test the potentially unfamiliar new skills in a safe environment. Doing so in group increases the likelihood that clients will try new skills in their lives outside therapy. As a result, roleplay in a group provides a valuable practice exercise.

Roleplay is specifically called for in the first group therapy session, in which clients are asked to practice marijuana refusal skills. While roleplay is not built into the remaining two group sessions, if time allows, therapists are encouraged to utilize roleplay when it may enhance learning. For instance, during the review of progress, a client may describe a recent relapse precipitated by an offer of marijuana. The therapist can encourage roleplaying in which the client responds by refusing the offer. Or during a later discussion of requesting help and support, a client could be asked to roleplay asking for help.

Some clients and/or therapists may feel uncomfortable or embarrassed at first about roleplaying. As a result, it may be tempting for the therapist to allow the group simply to talk about the skills rather than practicing them, which would decrease the effectiveness of therapy. Therapists can increase the likelihood that clients will participate in roleplays by taking the lead in the first one. Therapists should acknowledge that feelings of awkwardness are normal when trying a new interpersonal behavior like roleplay. Also, therapists are encouraged to praise clients who volunteer to go first. In general, if therapists establish a safe group environment and follow the suggestions about making group sessions fun and interesting, they are likely to find that clients will readily participate in roleplays. Here are the basic steps for setting up roleplays:

1. **Explain what roleplaying is,** if you have not already done so. Keep in mind that many clients are likely to be familiar with the idea of roleplay, so it may not require a long explanation. For example, say:

   I'd like you to practice turning down an offer to smoke by doing that here in group, as if you were acting. The first time, I'll pretend to be that guy you told us about.

2. **Briefly review the situation to be roleplayed**. What is the problem? What is the skill to be practiced?

   Okay, so your friend is driving you to school, and she offers to get high with you. You turn down the offer.

3. **Determine who will play which role**. Suggestions for acting the part can be solicited and made.

   Who would be willing to play Jason's mom?
   Jason, should she act mad, sad, or what?

The following strategies are useful in helping clients generate scenes:

- The therapist can ask clients to recall a situation in the recent past where use of the skill being taught would have been desirable.
- The therapist can ask clients to anticipate a difficult situation that may arise in the near future that calls for use of the skill.
- Clients can all be asked to write down scenarios to be roleplayed, fold them up, and place them in the center of the group. Clients then take turns taking one of the written scenarios and roleplaying them.
- The therapist can suggest an appropriate situation based on his or her knowledge of a client's recent circumstances.

After a roleplay has been set up and enacted, it is essential that it be effectively processed. It is an opportunity for clients to receive praise and recognition for practice and improvement, as well as constructive criticism about the less effective elements of their behavior. Initial attempts may show few elements of the communication skill being taught. During this portion of the session, the therapist's primary goal is to look for successful elements of the skill being taught and to reinforce those skill elements. The primary emphasis should be on what the client is doing well, in order to gradually shape his or her behavior in a positive direction. A secondary focus is making limited suggestions for improvement. Here are the procedures for delivering this feedback:

1. Immediately after every roleplay, the therapist should give the client reinforcement for participating and for positive aspects of the performance. Both the roleplaying clients should give their reactions to the performance. Examples: How do the protagonists feel about the way they handled the situation? What effect did the interaction have on the partner?
2. The other group members and the therapist should offer comments about the roleplay. These comments should be both supportive and reinforcing and constructively critical. If there are several deficiencies in a roleplay performance, the therapist should choose only one or two to work on at a time. Both positive and negative feedback should focus on specific aspects of the person's behavior, since global evaluations do not pinpoint what was particularly effective or ineffective. Finally, the praise and reinforcement provided should always be sincere. However, the therapist should refrain from being unnecessarily effusive, so that the value of the positive feedback is not undermined.
3. The scene should be repeated to give the client an opportunity to try out the feedback he or she received the first time around.

Role reversal is a roleplay strategy in which the therapist models use of the new skill, with the client playing the role of the friend, parent, or teacher. This strategy is particularly useful if a client is having difficulty using a skill or is pessimistic about the effectiveness of a suggested approach. By playing the "other," he or she has an opportunity to observe and experience firsthand the effects of the suggested skill.

Real Life Practice Exercises

Practice in real life situations is a powerful adjunct to treatment because it enhances the likelihood that these behaviors will be repeated in similar situations (generalization). Practice exercises have been designed for each session of the program. Most require that the client try in a real life situation what has been taught in the session. The real life practice assignment also requires that the client record facts concerning the setting, his or her behavior, the response it evoked, and an evaluation of the adequacy of his or her performance. Practice exercises can be modified to fit the specific details of individual situations.

Using practice exercises often is a problem, and a number of steps can be taken to foster compliance. The assignments are referred to as real life practice to avoid the negative connotations often associated with the term homework. When giving each assignment, provide a careful description of the assignment and the rationale for it. Ask clients what problems they can foresee in completing the assignment, and discuss ways to overcome these obstacles. Ask them to identify a specific time that can be set aside to work on the assignment, and try to elicit a commitment from group members to complete the practice exercise by the next session.

To emphasize the importance of practice, therapists should review the preceding session's exercise at the beginning of each session and make an effort to praise all attempts to comply with the assignment. Although problems that clients have with the exercises should be discussed and understood, the main emphasis should be on reinforcing the positive aspects of performance. If at least two group members have done the real life practice exercise assigned in the previous session, focus on those who have completed the assignment in this portion of the group meeting. To the extent that group members enjoy being the center of attention, this will reinforce completion of written practice exercises. For those who did not do an assignment, discuss ideas for complying with the next assignment. A selection of inexpensive but appealing items should be purchased by the staff, such as items that can be found at a party store or a dollar store (price range 50 cents to $1.25). At the end of the group meeting, let clients who have brought in a completed practice exercise choose one item from the assortment, to reinforce their compliance.

The next section of the treatment manual describes the procedures and content of sessions 3 through 5. Following that section are further recommendations regarding the management of problem behaviors.

Session 3: CBT3—Marijuana Refusal Skills

Key Points:

- One's social circle gradually narrows as marijuana use increases. Clean friends are avoided and socialization with users increases. It is crucial that clients attempting to stop smoking marijuana develop refusal skills.

- It is best to avoid people who put users at high risk, but that is not always possible.

- Clients need to develop refusal skills to handle pressure effectively.

- When being pressured to use marijuana, immediate and effective action is needed.

- Practice will increase the likelihood that clients will use their marijuana refusal skills effectively when pressured.

Delivery Method: Cognitive behavioral group therapy

Session Phases and Times:

1. Introduction of group members to one another and a brief review of progress (20 minutes)

2. Review of real life practice (personal awareness forms) (10 minutes)

3. Marijuana refusal skills (45 minutes)

Time: 75 minutes total

Handouts:

- Marijuana refusal skills handout—enough copies for all clients and the leader
- Marijuana refusal skills reminders and real life practice handouts—enough copies for all clients and the leader
- Blank personal awareness forms (homework from session 2)

Materials:

- Prizes (for completion of real life practice exercises)
- Pens or pencils
- A session 3 poster

Procedural Steps

Phase 1: Introduction to the Group and Brief Review of Progress. The first part of the session is allotted to introducing group members to one another and to reviewing rules, which are posted in the group room. In order to help focus the group, each client is asked to share his or her goal for treatment. The therapist then asks an open-ended question about how the past week has gone regarding the marijuana issues. Because the resulting discussion could probably continue for the rest of the session, the therapist will have to rein it in to allow time for the material in this session to be covered. To facilitate this, the therapist may wish to open the topic with a statement like:

> *Before we get into today's topic, let's take about 10 minutes to hear how things have been going for all of you this past week regarding the marijuana issue.*

Phase 2: Review of Real Life Practice. Next, the therapist will ask clients who have completed and brought in their self-monitoring records to pick one episode that they wrote about and share it with the group. Group members and the therapist then share their reactions to what was written. Again, the time prohibits getting into detail or an extended discussion of people's examples.

If none (or only one) of the group members have brought in written comments, give group members blank personal awareness worksheets (Knowledge Is Power) for functional analysis and have them verbally reconstruct one episode of craving or relapse that occurred during the past week. Allow time for feedback about those episodes. If at least two members have brought in written comments, just review their work. To the extent that members like the group attention, this may provide some incentive to complete the exercises. When people create answers on the spot rather than reading what they have written, they may become verbose; the time is better allotted to focusing on clients with written comments.

Phase 3: Marijuana Refusal Skills. Some of the following pointers and skills are included on the marijuana refusal skills poster, which provides visual reinforcement of the material to be covered. The therapist explains the following points regarding marijuana refusal skills:

1. **Being offered marijuana or being pressured to use by others is a very common high-risk situation** for marijuana users who have decided to stop using. Have you received such offers or pressures? In what situations?

2. As one's use increases, there appears to be a **"funneling" effect or narrowing of social relationships**. The individual begins to eliminate nonusing friends and his or her peer group becomes populated with others who support and encourage continued use. Being with such individuals increases the risk of relapse.

3. Given the increased risk associated with social pressure, **the best initial step is to avoid situations involving marijuana use**. As this is not always possible or practical, marijuana refusal skills are necessary.

4. Being able to turn down marijuana requires more than a sincere decision to stop using. It requires specific assertiveness skills to act on that decision. **Practice** in refusing marijuana will help you respond more quickly and effectively when real situations arise.

5. The more **rapidly** the person is able to say "no" to such requests, the less likely he or she is to relapse. Why is this so?

Next, the group should review specific suggestions for the nonverbal and verbal behaviors recommended for marijuana refusal (also shown on the marijuana refusal skills poster). The marijuana refusal skills handout covers this material but adds more detail. Distribute this handout, and review each of the skills. Consider having clients take turns reading the points, in order to keep them all involved. Demonstrate, and then engage the group in demonstrating, the skills described. Group members often enjoy the part of the group in which they see the skills demonstrated effectively rather than ineffectively, and this is a good opportunity to increase their active involvement in discussion. Point out that these refusal skills are equally useful in turning down offers to use alcohol or other drugs. Following are the skills to be reviewed with the group. (A handout follows.)

Marijuana Refusal Skills

Nonverbal behaviors:

- Be firm. Speak in a clear and unhesitating voice. Otherwise you invite questions about whether you mean what you say. *Demonstrate this skill by making the same refusal statement twice—once in a timid voice and once in a clear, firm voice. Have clients comment on the perceived effectiveness of each style.*

- Make direct eye contact with the other person; it increases the effectiveness of your message. *Again, demonstrate (or ask a group member to demonstrate) the same refusal with and without eye contact. Discuss your observations.*

- Stand up for your rights! Don't feel guilty. You won't hurt anyone by not using marijuana, so don't feel guilty. In many social situations, people will not even know whether you are using or not. You have a right not to use. *Discuss your reactions.*

Verbal behaviors:

- "No" should be the first word out of your mouth. When you hesitate to say "No," people wonder whether you really mean it. *Demonstrate the same statement both with and without the word "No" first. Ask for clients' reactions.*

- Besides saying "No," suggest an alternative, something fun to do instead. *Have the group suggest possibilities for alternative activities.*

- If a person repeatedly pressures you, ask him or her not to offer you marijuana any more. *Consider setting up a roleplay to illustrate doing this.*

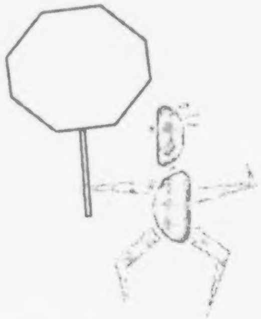
- After saying "No," change the subject to something else to avoid getting drawn into a long discussion or debate about using. *Have the group suggest possible changes of subject.*

- Avoid the use of excuses like "I'm on medication for a cold right now," and avoid vague answers like "Not tonight." *Discuss the rationale for avoiding excuses; they imply that at some later date you will accept an offer of marijuana.*

Marijuana Refusal Skills

Nonverbal behaviors:

- *Be firm. Speak in a clear and unhesitating voice. Otherwise, you invite questions about whether you mean what you say.*
- *Make direct eye contact with the other person. It increases the effectiveness of your message.*
- *Stand up for your rights! Don't feel guilty. You won't hurt anyone by not using marijuana, so don't feel guilty. In many social situations, people will not even know whether you are using or not. You have a right not to use.*



Verbal behaviors:

- *"No" should be the first word out of your mouth. When you hesitate to say "No," people wonder whether you really mean it.*
- *Besides saying "No," suggest an alternative, something fun to do instead.*
- *If a person repeatedly pressures you, ask him or her not to offer you marijuana any more.*
- *After saying "No," change the subject to something else to avoid getting drawn into a long discussion or debate about using.*
- *Avoid the use of excuses like "I'm on medication for a cold right now," and avoid vague answers like "Not tonight." These imply that at some later date you will accept an offer of marijuana.*

The next part of the session involves practice, and clients are generally quite good at generating appropriate scenes to practice. Initially, the therapist will play the person who is being invited to use marijuana and will explain and demonstrate each of the following types of responses:

Response Type	This Kind of Person:	Response Example
Passive	Tends to give up his or her own desire in favor of another person's desire. Doesn't let others know what he or she is thinking or feeling.	*"I didn't want to smoke pot tonight, but if you want us to, we might as well smoke."*
Aggressive	Acts to protect his or her own rights but runs over others' rights in the process, which can cause others not to like him or her.	*"I'm not smoking weed, and I don't want anyone smoking around me! I'm throwing everyone's weed away!"*
Passive-Aggressive	Is indirect, hints at what he or she wants, possibly causing confusion and/or resentment in others.	*"Are you all going to get stoned now? You know I'm in the treatment program. . . ."*
Assertive	States his or her position and makes a direct request.	*"I've quit smoking pot, and I'd like it if you would not ask me to smoke with you anymore. I still want to get together with you to do other things, like shooting some hoops, okay?"*

First, the therapist describes each of the four types of responses listed above, demonstrating an example of each by asking one of the group members to play the person offering the marijuana. The therapist points out the ways that the first three types of responses may not be helpful to clients, highlighting the differences between these styles and the desirable assertive style.

Next, the therapist encourages group members to practice the assertive style of marijuana refusal in roleplays with one another. Group members are encouraged to offer one another support and constructive feedback as they practice these skills. Finally, clients are each given a copy of the marijuana refusal reminders sheet to take home. They are asked to fill in the real life practice exercise at the bottom of the sheet with either: (1) responses they actually make during the week to people who offer marijuana, alcohol, or other drugs; or (2) things they could say to turn down an offer to smoke marijuana. The therapist should attempt to get a verbal commitment from group members to complete this real life practice exercise.

Marijuana Refusal Skills Reminders

When someone asks you to use marijuana, keep the following in mind:

- Say "No" first.
- Make sure your voice is clear, firm, and unhesitating.
- Make direct eye contact.
- Suggest an alternative:

  Something else to do.
  Something to eat or drink.

- Change the subject.
- Avoid vague answers.
- Don't feel guilty about refusing to use marijuana.
- If necessary, ask the person to stop offering you marijuana and not to do so again.

Real Life Practice

Listed below are some examples of people who might offer you marijuana in the future. Give some thought to how you will respond to them, and write your responses below each item.

Someone close to you who knows about your marijuana problem:

A school friend:

A coworker (if you have a job):

A new acquaintance:

A person at a party with others present:

A relative at a family gathering:

Session 4: CBT4—Enhancing the Social Support Network and Increasing Pleasant Activities

Key Points:

- Social support leads to improved confidence in one's ability to cope and provides an additional source of help for quitting or reducing one's marijuana use.

- Often individuals do not have as much support as they would like.

- There are several potential sources of support, including one's family, friends, and acquaintances.

Delivery Method: Group cognitive-behavioral therapy

Session Phases and Times:
1. Review of progress (15 minutes)
2. Review of real life practice exercise (10 minutes)
3. Enhancing support (35 minutes)
4. Increasing pleasant activities (15 minutes)

Time: 75 minutes total

Handouts:
- A social supports reminder sheet for each group member
- A social circle worksheet for each member
- A social support practice exercise sheet (entitled Real Life Practice: Seeking and Giving Support) for each member

Materials:
- A drug test kit for each client
- Prizes (for completion of the real life practice exercise)
- Pens or pencils
- A blackboard, a "write and wipe" board, or a large poster board
- A session 4 poster

Procedural Steps

Phase 1: Review of Progress. Prior to formally beginning the group session, clients should be asked to provide urine samples for drug testing. The therapist waits outside the restroom when each client goes in to provide the sample. Clients should not be permitted to bring extra items into the restroom (e.g., coats, purses, etc.). If a multiple-capacity restroom is used, only one client should be allowed into the restroom at a time. When clients bring out their urine samples, the therapist should look at the temperature strip on the outside of the container to see whether the urine was voided recently (i.e., is within the expected temperature range). Clients should be informed that if they do not provide the requested urine sample, or if the sample is invalid, their sample will be considered positive for drugs.

meaning that drugs were present in their urine sample. If some clients say that they are unable to urinate prior to the group meeting, ask them to wait until after the meeting to do so. Occasionally a group client may say that he or she must use the restroom during the session and is unable to wait until afterward. In such a case, try to have a support staff person who is outside the group supervise the client providing the urine sample (as described above), rather than interrupting the group to supervise that client yourself.

After obtaining urine samples, begin the group meeting. Following initial greetings and updates (for example, telling the group that a client will not be in that day), the therapist should start with a general question about recent progress. For example:

> *As you've been working on the marijuana issue over the past week, has anyone had any problems or successes that you'd like to share with the group?*

Allow sufficient time for discussion, attempt to facilitate members' feedback and reactions, and offer your own comments, using MET and CBT strategies where possible. Move into the practice exercise review part of the session when the discussion winds down or in 15 minutes, whichever comes first.

Phase 2: Review of Real Life Practice. As in last week's group session, keep the focus primarily on those who have done the real life practice exercise, unless fewer than two clients have done so. Have members read their responses to the refusal skills real life practice exercise, with the rest of the group offering feedback. Ask if any group members have had an opportunity to try out their refusal skills in a real life situation. If so, ask them to tell about their experience and reinforce their efforts.

Phase 3: Enhancing the Social Support Network and Increasing Pleasant Activities. This phase of the session starts with the therapist reviewing the rationale for increasing support:

- Social support leads to improved confidence in one's ability to cope and provides an additional resource.
- Individuals do not often have as much support as they would like.
- There are several potential sources of social support, including one's family, friends, and acquaintances.

Next, focus on teaching social support skills. Distribute the enhancing social supports reminder sheets (adapted from Monti et al., 1989) to the group. These skill guidelines are summarized on the poster for this session. Review the guidelines with the group and have them come up with examples from their own lives that correspond to some of the items. Here are the areas covered on the reminder sheet, with suggestions for covering them:

Enhancing Social Supports

Who might be able to support you? (*Tell the group that "this refers to people who could help you with the goal you set regarding your marijuana use, as well as with other concerns in your life."*)

Consider people who usually have been supportive in the past or those with no bias toward you. *(Encourage group members to give examples from their own lives.)*

Consider people who usually have been neutral in the past (who aren't coming in with a bias against you). *(Encourage group members to give examples from their own lives.)*

Consider people who usually have not been supportive in the past but who might become supportive when they see your effort. *(Encourage group members to give examples from their own lives.)*

Consider friends, family, acquaintances, or others in your community. *(Prompt the group regarding categories that have not already been covered and may apply to group members, for example, teachers, clergy, coaches, extended family, guidance counselors.)*

What types of support will be most helpful? *(Again, have the group think of examples from their own lives of when they have needed, or when they may need, each of these types of support in the future.)*

Help with problem solving—someone good at thinking of options

Moral support—someone to offer encouragement and understanding

Sharing the load—help with getting things done

Information—about activities, transportation, getting a job, etc.

Emergency help—for small loans, needed items, a ride, etc.

How can you get the support or help you need?

Ask for what you need. Be direct and specific.

The therapist should model the following ways of seeking support for the group. You may prefer to substitute a situation described by a group member during the meeting for the example below.

Problem: The client wants a friend to show support by doing things together other than just smoking marijuana.

Type of Request for Help	Response Example
Indirect	The only thing you ever want to do with me is smoke pot.
Direct, but not specific	I'd like to spend time with you doing stuff other than smoking pot.
Direct and specific	I'd like to spend time with you, but I don't want to smoke pot any more. Why don't we go bowling this Saturday night?

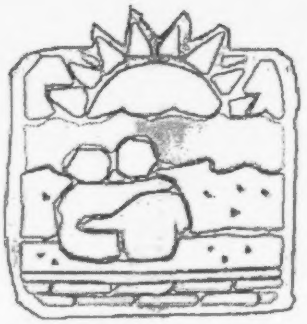
Ask for group members' reactions to the situations as they are modeled.

Add new supporters. As you work on something new, like trying to quit marijuana, you may need new or additional supporters. *Ask group members who else's support they could seek.*

Lend your support to others. *Talk with the group about how giving support allows you to get better at receiving support. Ask them for their reactions to this idea.*

Give your supporters feedback. Let them know when something is or isn't helping. *Have the group think of an example of when someone may try to offer support that is not helpful, and how someone could tell them so.*

Enhancing Social Supports Reminder Sheet



WHO might be able to support you? Consider people in the past who have been:

- Usually supportive, such as friends, family, acquaintances, or others in your community
- Usually neutral (aren't coming in with a bias against you)
- Not supportive, but might become supportive when they see your effort

WHAT types of support will be most helpful?

- Help with problem solving–someone good at thinking of options
- Moral support–offers encouragement and understanding
- Sharing the load–help with getting things done
- Information–about activities, transportation, getting a job, etc.
- Emergency help–for small loans, needed items, a ride, etc.

HOW can you get the support or help you need?

Ask for what you need. Be direct and specific.

- Add new supporters. As you work on something new, like trying to quit marijuana, you may need new or additional supporters.
- Lend your support to others. It allows you to get better at receiving support.
- Give your supporters feedback. Let them know when something is or isn't helping.

Adapted from Monti et al., 1989

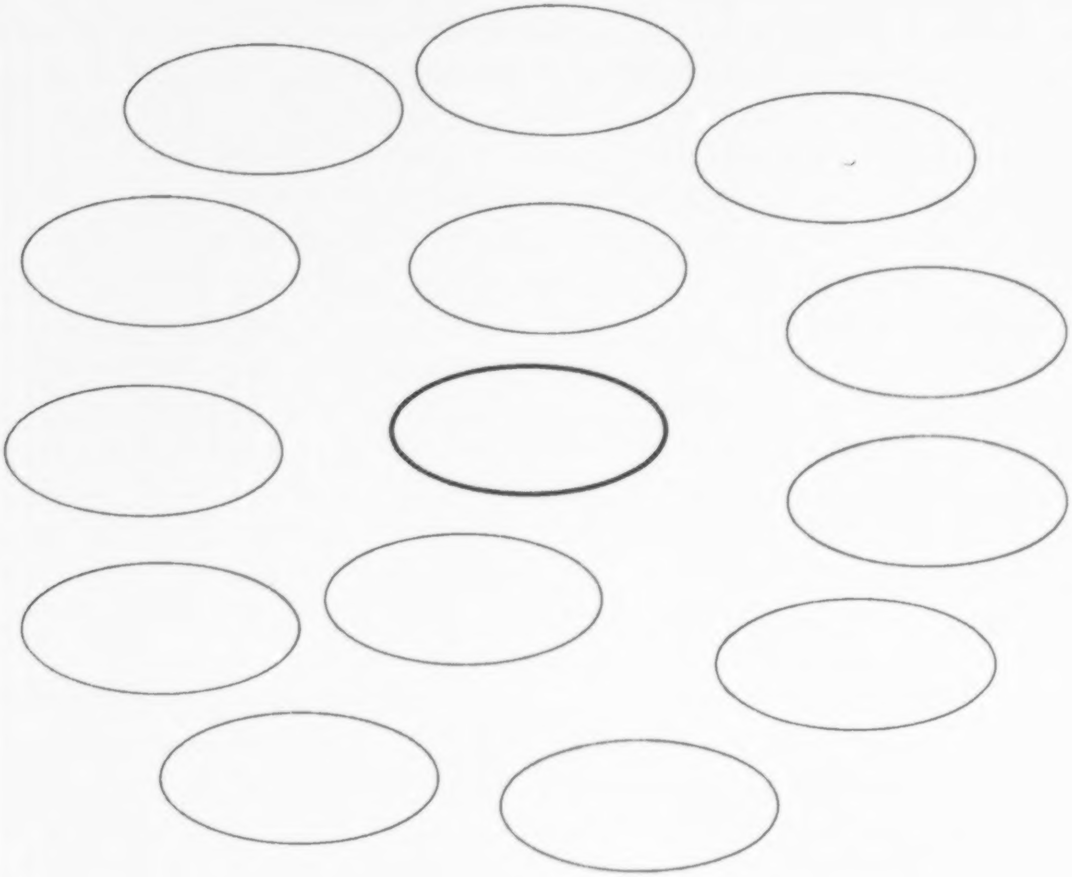
In-Session Exercise: Social Circle Diagraming. Next, group members are asked to diagram their own social circles and to try to determine what support they may be able to obtain from their social circle. They are given pencils and asked to fill in this diagram during the next part of the group meeting.

After 5 to 10 minutes, each group member is asked to share what he or she learned or noticed about his or her own support system. Did group members notice possibilities for asking for and getting more support? They are not asked to share the specifics of their personal support system; there is not enough time for this. Although clients may want to explain every intricacy of their social circle ("Here we have my friend Casey; this is my sort-of friend Joe," etc.), time will not allow this detail. It will be helpful for the therapist to explain this at the beginning of the discussion to decrease the likelihood that a client will feel cut off later. Please see the social circle diagram on the next page.

Social Circle Diagram

Use the grid below to diagram your own social support circle, focusing on those who could support you in addressing your marijuana issue.

Put your name in the center space, then fill in the names of those who do and/or could support you in your goal. Put the people who could be of greatest support to you closest to your space. Fill in as many of the spaces as you can.



Phase 4: Increasing Pleasant Activities. The following exercise is offered as a possible supplement to this session and should be included if there are at least 15 minutes available. Enjoyable activities can be a positive alternative to smoking marijuana. The group is asked to think of pleasant, fun, and safe activities that may serve as an alternative to smoking marijuana.

Tell them that some frequent marijuana smokers forget what it is like to do various things when they are not high and that some fun activities seem normal to them only when they are under the influence. Stopping or reducing marijuana use involves breaking the connection between these activities and being high. Many marijuana smokers may think that these activities will not be fun any more without marijuana, but they are often pleasantly surprised to find that the activities are as much fun, or even more fun, when they are not under the influence. Tell them that you'd like them to think of healthy, fun activities that they may be able to enjoy without, and instead of, marijuana use.

In-Session Exercise. While the group brainstorms possibilities, the therapist writes them down so that they are visible to the whole group. After several minutes, the therapist asks the group to consider if there might be a few activities on the list that they could add to their routine of activities. They are asked to write some of these on the bottom of their social circle diagram.

Next, they are asked to circle any of the listed things they would be willing to do over the next week. Each client is encouraged to tell the group one new thing he or she will do over the next week, including when, with whom, and how they will do it. Remind them that the idea is to do the chosen things without using marijuana, alcohol, or other nonprescribed drugs.

Distribution of Practice Exercises. Before the session concludes, practice exercise sheets (entitled Real Life Practice: Seeking and Giving Support) should be distributed and group members asked to complete them before the next session. Have the clients read the practice exercise sheets in the session so that they can ask any questions they may have at that time. Try to elicit some type of commitment from group members to complete both the written part of the exercise as well as the part where they actually ask for and offer support. This is in addition to trying out the pleasant activity.

Real Life Practice: Seeking and Giving Support

Think of a current problem that you would like help with.

Describe the problem: ____

____

Who might help you with this problem? ___________________________

____

What might he or she do to give you the support you'd like?

____

How can you get this support from him or her? Remember, be direct and specific: ____

____

Now, choose the right time and situation, and try to get this person to support you. Describe what happened: ____________________________

____

Offer support to someone else.

Name a friend or family member who is currently having a problem and who could use more support from you: _________________________

____

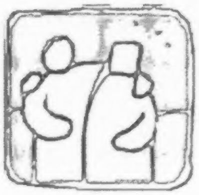
Describe what you could do to lend him or her some support: _________

____

Now, choose an appropriate time and setting, and give support to this person. Describe what happened: ______________________________

____

Adapted from Monti et al., 1989



Session 5: CBT5—Planning for Emergencies and Coping With Relapse

Key Points:

- Preparation for emergencies (unanticipated high-risk relapse situations) will increase the likelihood of effective coping.
- The group will brainstorm events that could precipitate a relapse.
- The problem-solving approach will be introduced as a way to cope with unforeseen events.
- A relapse is likely to be accompanied by guilt and shame, which exacerbates the problem.
- Use emergencies and lapses as learning opportunities.

Delivery Method: Cognitive-behavioral group therapy

Session Phases and Times:

1. Review of progress (15 minutes)
2. Review of real life practice (15 minutes)
3. Planning for emergencies and coping with relapse (35 minutes)
4. Termination (10 minutes)

Time: 75 minutes total

Handout:

- A personal emergency plan handout for each client

Materials:

- A blackboard, a "write and wipe" board, or a large poster board
- A session 5 poster

Procedural Steps

Phase 1: Review of Progress. Like previous group sessions, this session begins with a review of progress. Discussion about progress or problems over the past week is elicited by a general inquiry by the therapist. (See sessions 3 and 4 for further recommendations for conducting the review of progress.) During this phase of the group, the therapist offers to communicate the results of the clients' urine tests for drugs (from samples obtained at the previous group meeting.) See "The Five Strategies of Motivational Enhancement Therapy" on page 21 for recommendations for discussing these results. The therapist should remind group members that this will be the final therapy session.

Phase 2: Review of Real Life Practice. Have group members read their responses to the seeking and giving support practice exercise. Ask the rest of the group to offer feedback. Reinforce attempts to try out the enhancing social support network skills through real life practice. If some clients have not yet tried out these skills, encourage them to do so soon. Ask them to make a commitment to do this.

If the pleasant activities segment was done in session 4, ask clients about how they did on their plans to increase pleasant activities. Did they do the thing they planned? How did it go? Did they enjoy the activity or not? If they didn't do it, what got in the way?

Phase 3: Planning for Emergencies and Coping With Relapse. Even if someone avoids situations involving marijuana use, knows how to refuse such offers, increases his or her support system, and plans positive alternative activities, he or she still may encounter unanticipated high-risk (emergency) situations and may relapse.

In-Session Exercise: Group Brainstorming of a Potential Emergency Situation. For individuals attempting to quit marijuana, an emergency situation consists of unanticipated circumstances that place them at increased risk for marijuana use. The group is asked to brainstorm the types of emergencies they may encounter. The therapist writes down the group's responses in a place that is visible to all group members. After a period of unstructured brainstorming, provide cues to help the group think of types of emergencies they may have missed. Here are some examples of emergencies:

Type of Emergency	Example of Emergency
Unanticipated trigger	*Encountering substance abuse at a drug- and alcohol-free dance*
Social separation	*Friend moves away; breakup with boyfriend or girlfriend*
School problem	*Failing to be promoted; getting suspended*
Adjustment to a new situation	*Move to a new town; parents divorce*
New responsibilities	*New job; care for a sick family member*

As seen above, emergency situations that can trigger a slip do not just include negative events but can also include positive events (e.g., a new job or a move to a better home). These situations entail the need to adjust to a number of changes in one's environment and routine, when one's coping skills may no longer fit the new circumstances. In emergency situations, individuals can increase their likelihood of success by using the problem-solving model described below, an approach developed by D'Zurilla and Goldfried (1971).

Presentation of the Problem-Solving Model. The following brief summary of the problem-solving model is derived from *Treating Alcohol Dependence: A Coping Skills Training Guide* (Monti et al., 1989), which asks:

1. **"Is there a problem?"** Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behavior, our reactions to other people, and the ways that other people react to us.

2. **"What is the problem?"** Identify the problem. Describe the problem as accurately as you can. Break it down into manageable parts.

3. **"What can I do?"** Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.

4. **"What will happen if. . . ?"** Select the most promising approach. Consider all the positive and negative aspects of each possible approach, and select the one most likely to solve the problem.

5. **"How did it work?"** Use the chosen approach. Assess its effectiveness. Having given the approach a fair trial, does it seem to be working out? If not, consider what you can do to beef up the plan, or give it up and try one of the other possible approaches.

Group Practice Exercise: Problem Solving for Emergencies. Have the group select one of the potential emergencies that were generated in the previous brainstorming exercise. Now ask the group to be sure that the problem is clearly identified, and have clients brainstorm various solutions. Write the possible solutions in a place that is visible to the whole group. Now have the group evaluate each of the possible solutions and pick one as the best choice. As this exercise is being done, describe how these brainstorming steps fit in with the problem-solving model.

Group Discussion: Coping With Relapse. Engage the group in discussion about coping with a relapse that may occur in response to an unanticipated high-risk situation. Here are some points to cover:

- **Relapse is not uncommon in recovery.** The important thing is how one deals with a relapse. Clients may think that after one relapse, the whole recovery plan is ruined, and they might as well give up. Let them know that this does not have to be the case.

- **Clients may learn something from a relapse.** Tell them that by looking at the circumstances of the relapse, they may learn situations to avoid, or changes to make in their coping skills.

- **Clients can choose to resume their efforts to live without marijuana after a relapse.** Ask the group for ideas about how someone could get back on track. Help the group cover the following suggestions:

1. Get rid of any leftover marijuana.
2. Ask for support.
3. Do other positive things instead of using.
4. Remind yourself of reasons for wanting to quit.

Individual Practice Exercise: Developing a Personal Emergency Plan. By developing a plan ahead of time, clients will be less likely to be sidetracked by unanticipated emergency situations. Each client is given a blank personal emergency plan worksheet and asked to think about numerous solutions to each of the categories presented on it. Then he or she is to select the one or two he or she thinks may be the best generic plan. Of course, these plans will have to be somewhat general because of the unpredictable nature and circumstances of future emergency situations. Group members begin filling out these sheets in the group, to the extent that there is time available, and they are asked to complete this exercise at home.

Phase 4: Termination. The final 10 minutes of the group are set aside for a discussion of termination of therapy. Group members are asked what it has been like for them to participate in the group. They are given the opportunity to offer feedback to one another and/or to the therapist. Try to keep feedback to peers positive and supportive. Also, ask the clients their goals from this point regarding marijuana. After 10 minutes of termination discussion, the group concludes.

Personal Emergency Plan

Plan for:_______________________
Name

Here are some possible emergencies that I want to be prepared for:
____
____

If one of these emergencies happens, this is how I will help myself cope:

⟹ DO the following:

- ___ Think things through.
- ___ Cool down by: ____________________________
- ___ Distract myself with:
  - ___ Physical activity. What kind? ______________
  - ___ Doing something relaxing. What? ____________
  - ___ Media (music, book, magazine, TV, movies). Which media?____________________
  - ___ Something creative (writing, art, dance). Which one(s)? _____________________
  - ___ Ask or call someone for help

Helpful People

Who	Phone Number

⟹ DON'T DO the following:

- ___ Smoke marijuana, drink alcohol, use drugs.
- ___ Act without thinking.
- ___ Get overemotional.
- ___ Isolate myself and/or stay away from people who care about me.
- ___ Stay in a high-risk situation.

If the emergency involves a relapse to marijuana use, the following steps will help me stop using:
____
____

VII. Common Treatment Issues

Below are some recommendations for handling some common treatment issues. In general, most of these issues are managed best by skillful screening and assessment and the clear communication of the expectations and rules for group participation. When the following treatment issues occur, the therapist is advised to consult with his or her supervisor to determine the most appropriate response, taking into account the unique characteristics of the client and the situation. The first issues discussed may be applicable to both individual and group therapy. The final issues are relevant to the group sessions.

Client Issues for Group and Individual Sessions

Clients Showing up High

Clients who are under the influence of alcohol, cannabis, or other nonprescribed drugs will not be allowed to participate in that therapy session. This situation calls for:

1. An assessment of the need for detoxification
2. Notification of a parent or guardian (because of potential safety/liability issues)
3. Evaluation of a potential threat to public safety (e.g., a client driving an automobile when leaving the treatment site).

Ideally, clients who are under the influence of drugs or alcohol will be identified prior to the start of a group session and prevented from entering the group, but this is not always possible. If a client is already in the group when the intoxication is noticed or reported, he or she will be asked to leave the group. The backup staff person will supervise this individual.

If a group member is removed from the session due to acute substance use, ask the rest of the group members how observing this situation has affected them. Encourage them to verbalize their feelings. Ask the other group clients if this has been a trigger for them to use as well. If so, help them develop a plan to take care of themselves without using drugs or alcohol.

Threats to Harm Oneself or Others

Clients' threats to harm themselves or others in individual sessions should be evaluated immediately (and just after the session for those occurring in group sessions). Concerns regarding a risk to oneself or others should immediately be brought to the clinical supervisor by the therapist. A supervisory review will help determine the best clinical response and the agency's ethical/legal duty to warn someone or intervene. Threats of harm to oneself or others should bring about an immediate reevaluation of the severity of the problem and modality placement.

When a client verbalizes suicidal impulses or impulses to harm a person outside the group, the therapist should make it clear to the group that he or she will address this concern with the client right after the group meeting. It is important for the other clients to know that such statements are taken seriously. Check with clients regarding whether they have become distressed and/or whether hearing such a statement was a trigger to their own problem.

When a client verbalizes a threat to another group client, the therapist should immediately set limits by reminding clients of the group rules. The threatening client should be asked to leave the group session. Ask him or her to wait until the group is over to speak with a therapist. After the group, discuss the seriousness of making such threats and attempt to assess the risk they present. The therapist may consider telling the offending client that it is not yet clear if he or she will be permitted to return to future group meetings. This gives the therapist the opportunity to discuss the situation with a supervisor before informing the client of a decision.

Tardiness

Clients should not be allowed to enter therapy sessions more than 15 minutes after the time the session was scheduled to start. The therapist may use his or her own judgment regarding exceptions to this policy (that is, for clients who have a valid excuse for their tardiness). The therapist should also take into account the expected extent of disruption to a group session, as well as the likelihood that the client will obtain therapeutic benefit from his or her late entry to the session. Therapists should document the amount of time missed from the session.

Missed Sessions

Because of the brevity of this treatment, clients should complete at least 80 percent of the treatment (four sessions) in order to be considered treatment completers. As described in earlier sections of this manual, attempts are made to increase the likelihood of treatment completion by reinforcing the importance of treatment attendance and by making telephone calls to confirm appointments. No makeup will be required for clients who miss a single session, but clients who miss two or more sessions will be provided with the option of makeup sessions. The individual MET sessions can be made up simply by rescheduling them. Missed group CBT sessions are to be made up by meeting with the client 15 minutes before or after another group. If more than one client must make up the same session, these clients can be seen together. It is generally most convenient to schedule makeup sessions just prior to or after a regular group session. Makeup sessions may be somewhat abbreviated, with the focus on reviewing the main points covered in the missed session. A low-level safety net should exist whereby an adolescent missing two successive sessions, while potentially considered for discharge from the group, should be assessed by telephone for possible clinical deterioration. If there is evidence of clinical deterioration, this should be reviewed with the supervising therapist/coordinator.

Issues in Group Sessions

Disruptive Behaviors in Group Sessions

In general, every effort will be made to manage disruptive behavior by having the therapist reassert group rules and by providing therapist and peer feedback. To encourage compliance and to reduce the likelihood of behavioral problems in group, the therapist should clearly delineate the group rules at the beginning of each of the group meetings. Interventions (during the group and/or following group) to modify disruptive behavior and remotivate a client will be attempted before expulsion from the group. If a client continues to violate group rules despite repeated corrective feedback, he or she will be asked to leave the group. In preparation for this possibility, designate a support staff person prior to each session, and always be available in the event of an emergency and/or the removal of a member of the group. This staff person either could supervise the client removed from the group room and/or call for emergency assistance, if needed. Visual supervision should be implemented any time a group member leaves the group session due to disruptive behavior and/or emotional distress. Any removal of a client from a group session should trigger a reevaluation of the type or level of service needed by the client.

Group members may exhibit a wide range of behaviors that may trigger other group members to challenge the authority of the therapist or disrupt the group's focus. One method of disruption is to tell war stories (i.e., accounts that present drug and alcohol use in a glorified light). Therapists should point out what is happening and divert the discussion. This often can be done—with humor yet redirection—in a manner that avoids setting up an intense battle for control between the client and the therapist. For example, "Okay, okay, we get the point that you like to get high. But when you tell it like that, it might make others feel like they should start smoking again."

Group members may attempt to challenge the therapist's authority and/or make the therapist squirm by asking about his or her experiences regarding marijuana. Therapists may choose to answer such questions or not, depending on their own preferences about handling personal disclosure. The therapist should remember that such questions generally are not so much about needing to know the therapist's history as they are about the clients' concerns about whether the therapist can understand them. Here, again, an expression of empathy will go a long way toward addressing this question.

Other problematic and disruptive behaviors may include inappropriate sexual comments, interrupting other group members, side conversations, excessive profanity, references to gangs, and threatening behaviors. As described above, the focus is on managing these behaviors within the group session by reiterating group rules, attempting to shift the interaction rather than engage in a control battle, making empathic comments where appropriate, and utilizing the feedback of other group members. If the behavior continues and escalates, the disruptive group member(s) should be asked to leave the group. The therapist should use his or her clinical judgment to determine if the client will have the opportunity to return to that session after the problem behavior has ceased, or if he or she will be excluded from the remainder of the session.

Breach of Confidentiality by Group Members

The response to this would be similar to those noted above, i.e., the therapist reminds the errant client of the group rule regarding confidentiality and asks that client to recommit to adhering to that rule. In the case of a breach of confidentiality, greater emphasis on peer feedback and pressure is made. For example, the client whose confidentiality was breached may tell the erring client of the effect of his or her behavior on him or her. Other clients may be asked to talk about their own confidentiality concerns. The group should be told that further violations of this rule could lead to termination from the group.

Request for Individual Attention Outside Group Sessions

Individual consultation after completion of the two MET sessions is discouraged, other than when it is necessary to address issues of clinical deterioration. If a group member asks to discuss a problem with a therapist privately, explore the reasons for the request. Usually it will be sufficient to reassure the client that the matter is appropriate to discuss in the group.

Client Participation Problems in Group CBT

Because of the brevity of the MET/CBT5 therapy, it is particularly important that clients be given sufficient time and attention in each of the therapy sessions. In group therapy sessions, attending to each group member may be hampered by some imbalances in the extent to which each member participates. Lewinshohn and colleagues (1984) have suggested that some group therapy members can be characterized as either "monopolizers," who dominate the group discussion and seek attention, or "nonparticipants," who show little or no participation in the group. In CYT, similar subtypes of clients reflecting either extremely active or inactive participation were observed during the CBT groups. The therapist needs to balance the time and consideration that each group member receives to ensure they all receive sufficient attention in therapy. The two sections following describe some strategies for dealing with both monopolizing and inactive group members.

Monopolizers in Group CBT

Some clients may speak so much in group CBT sessions that they monopolize the group's time and attention. If this situation is not addressed, the rest of the clients may not get the therapeutic attention that they require. This is a problem because the other members may lose interest in the therapy. Also, the therapist may miss issues of concern regarding the other group members. The monopolizer needs to be asked to speak less in the group session, but the request must be made in such a way that he or she is not humiliated or alienated. Remember that adolescents are especially sensitive to being embarrassed in front of their peers. This section provides some ideas for dealing with monopolizers in a therapeutic manner.

It helps to understand some of the reasons adolescents show these monopolizing behaviors. Three common reasons are:

- Neediness
- Impulsivity or attention problems
- Antisocial characteristics.

Here are some ways to identify these types of monopolizers and to tailor responses accordingly.

Needy Monopolizers

Many adolescents with substance abuse problems also experience interpersonal problems, including estrangement from satisfying family and peer relationships. As a result, some clients may feel especially lonely and neglected. When both a kind therapist and a group of adolescents with similar problems listen to them, they may be so pleased to have the group's attention that they get carried away. This needy monopolizer can be identified; his or her comments are likely to be task oriented and generally prosocial. The key to dealing with these clients is to keep in mind that their behavior comes from a desire to be noticed and appreciated. Point out what they are doing well, and frame requests that they speak less in the group session in terms of helping the rest of the group. For example:

> *You are coming up with some great examples. It's really clear that you have thought about this. I'm going to ask you to hold off now a bit, to help encourage other folks to do that, too. Okay?*

Some of these clients really enjoy a task like writing the group's comments on the blackboard during a brainstorming exercise. This allows them to have a special role in the group, while allowing the other clients to participate verbally.

Impulsive Monopolizers

Other adolescents frequently may interrupt and/or talk at length in the group sessions due to impulsivity or attention problems. These clients can be identified because their comments may frequently be off task; i.e., they may talk about all sorts of topics that are unrelated, or loosely related, to the topic being discussed in the session. Many such clients are also easily distracted by extraneous environmental stimuli (e.g., sounds outside the group room). Some of their monopolizing comments may relate to these distractions. Often these clients are aware of these attentional problems and are generally comfortable with good-natured requests by the therapist that they come back to the task at hand. Many of these clients also respond well to a combination of both verbal and visual cues; the therapist is encouraged to use gestures and hand signals with verbal comments to redirect impulsive monopolizers. For example, the therapist can smile and hold his or her hand up as a stop signal while saying, "Let him finish what he was saying first." Another useful gesture is to make a "T" for time out when encouraging a client to wait before speaking. In addition to helping the client contain his or her impulsive comments within the group sessions, when a client has been demonstrating marked problems with impulsivity and attention, the therapist should consider whether a client may benefit from a referral for evaluation and possible treatment of this problem. Such questions should be addressed in supervision.

Antisocial Monopolizers

Another type of monopolizer is a group member who attempts to challenge the group leader's authority and demonstrate power over what the group will do and discuss. This type of client often tries to steer the discussion away from the task at hand and onto negative topics, such as attempting to brag about his or her substance use and related antisocial activities, including fighting, criminal activity, and promiscuity. These clients may subtly, or not so subtly, pressure and intimidate the rest of the group members to follow their lead. For example, if another group member tries to change the topic back to something on task, the antisocial monopolizer may look at that member and roll his or her eyes as though that member is not cool. These antisocial monopolizers may appear to set up a game in which they win by taking control of the group and defeating the group therapist. Sometimes these clients may bring up angry feelings in the therapist because of their blatant disrespect and their negative effect on the attitudes of the other group members.

The key to dealing with these participants is for the therapist to set limits and redirect them without letting his or her own angry feelings come out in a counterattack, such as sarcasm or shaming. If the latter occurs and the therapist fights fire with fire, the antisocial monopolizer frequently escalates the negative behavior. The therapist should say something direct and firm and may find it useful to refer to the group rules and/or to the impact on other group participants. For example, "I'm going to have to cut you off. Remember that we went over the group rule about not telling war stories. I don't want it to trigger other group members."

If the therapist sees that a pattern is developing in which group members are beginning to feel that it is preferable to follow the lead of the antisocial monopolizer lest they do not appear to be cool, it can be useful to talk to the group about this. The therapist can say something like, "I could be wrong, but it appears to me that a number of group members are coming across like it's only cool to keep using drugs and that it's not cool to stop using. If that's the case, I'm worried that it could make it hard for folks who want to stop." After such a statement, group members may be inclined to disagree with the therapist's statement, making such statements as, "No, that's not how we feel. It's cool either way." It is not necessary to get clients to agree with the therapist's statement in order for it to be effective. Often just stating the concern may decrease the likelihood that participants will continue to speak in such a manner. If they do, the therapist can say (with a smile) something like, "This is the sort of thing I was talking about. C'mon, let's get back on track."

Working With the Participant With Cognitive or Perceptual Impairments

Adolescents with substance use disorders may present with cognitive or sensory/perceptual impairments that are due to cumulative toxic effects of abused substances, brain injuries, or developmental disorders. As a result, the MET/CBT5 therapist needs to be prepared to adapt the approach for these clients. The following characteristics are indications of possible cognitive or sensory/perceptual impairment:

- Distractibility and shortened span of attention
- Difficulty understanding questions and concepts
- Frequently losing the train of thought in the middle of a sentence or idea
- Getting stuck on one thought and repeating it numerous times (perseveration), despite attempts by the therapist to address the concern
- Appearing generally confused
- Limited ability to generalize (i.e., apply new learning to different situations)
- Difficulty understanding abstract thoughts.

When such signs are evident, the therapist should consider whether the client may benefit from a referral for a neurological or cognitive evaluation. If the client appears to have a visual or hearing problem that could account for his or her difficulty, ask about this and attempt relevant modifications, such as speaking louder, providing enlarged photocopies of printed materials, or minimizing background noise. When the problem appears to be cognitive rather than sensory, the following therapeutic modifications are recommended in both individual and group therapy sessions (these modifications are not intended to replace referral for specialized evaluation and remediation):

- Use simple, short sentences.
- Simplify ideas and language, and use concrete examples rather than abstract concepts.
- When a new idea is presented, check whether the participant understands it.
- Repeat ideas and information, both within and across sessions.
- Provide a lot of practice of new learning.

For those who would like more information or clinical guidance regarding this topic, Weinstein and Shaffer (1993) provide a detailed review of the neurocognitive deficits likely to be found among substance abusers, along with targeted clinical strategies to remediate them.

Inactive Members in Group CBT

In contrast to monopolizers, some clients may participate so infrequently in the CBT group sessions that they are generally inactive group members. This is a problem because these inactive members may get little out of treatment, and other group members may be uncomfortable with their inactivity. The therapist should try to encourage these clients to participate more. Because the CBT sessions include some in-session exercises in which each client is asked to share his or her response, this helps ensure that each participant gets a chance for attention. Make sure that each client gets a turn to talk and that the rest of the group members pay attention when each member does so. Group members are more likely to engage in side conversations when less-well-liked members are presenting. When this occurs, the therapist should set limits through comments like, "Please be quiet; Jessica is speaking. Let's show her some respect. Sorry, Jessica; please go on."

Again, having a sense of why clients may be inactive helps guide a therapist's response. Three different types of inactive group members are discussed below: those who are anxious, angry, or cognitively impaired.

Anxious Inactive Members

Some inactive members may be anxious, shy, or frightened, as shown by their nervous movements, soft speech, and hesitant responses. Here are some things the therapist can do to help these participants feel more comfortable:

- **Directly involve them in the discussion** by inviting them by name: "Derrick, what do think about that?" Try asking them something that is not a difficult, anxiety-provoking question.
- **Involve them** by asking them to read some of the skill guidelines during the session, unless they have shown impaired reading ability during the individual sessions.
- When members pair up for roleplay exercises, **suggest ways to pair people up** so that these members are not usually the last ones to find a partner.

Angry Inactive Members

Members may also be inactive because of their resentment and anger about being in treatment, especially if they feel they were forced to attend against their will. They may communicate their angry feelings through nonverbal cues like sighing, folding their arms, or making faces. A useful approach with these inactive members is to tell them what you see in a nonjudgmental tone and to invite them to talk about their feelings. Here is an example that does both: "Hearing you groan like that, it seems like you may be angry. Could you talk about what's going on?" That participant may still decline to speak, but such a statement may help increase the likelihood of his or her future participation. In addition, it helps the rest of the group to see that the therapist notices what is going on. As a result, they are less likely to be anxious and distracted by the angry, inactive participant. It may be useful to normalize such feelings of anger by saying, for example, "I know that sometimes people feel that they were forced to be here by the legal system or their parents, and understandably that can make them angry. Does anybody relate to that?" The therapist can express some hope that there may be aspects of the sessions that can be helpful or at least "acceptable," despite the fact that some feel pressured to attend.

Cognitively Impaired Inactive Members

Finally, some participants may be inactive during group sessions because they have cognitive impairments that make it difficult for them to keep up with the rest of the group. Their thinking may be more concrete, and they may have difficulty following some of the comments made by both the group leader and by their fellow participants. The group leader can help these participants by doing the following things:

- **Try to keep explanations simple.** When difficult ideas are expressed, casually repeat them in a simple, translated form to the entire group. Obviously, if the simplified explanation is directed to only one member, that client could feel humiliated.

- **Create a safe atmosphere for asking questions** about concepts or words that are not understood. For example, when a client says, "What does 'hesitant' mean?," say "I'm glad you asked. Sometimes people are afraid to ask and just feel like they have to pretend to understand everything." Then explain it simply.

- Sometimes these group members may make a comment that is a painful demonstration that they are out of it as far as understanding what is being said. The main concern is to **prevent them from being mocked by the other clients** when this occurs. Try to look for something that is accurate or relevant in what they have said (which generally can be found if the therapist is creative). Make a comment reflecting the accurate part of what the client has said, and then correct the part that is inaccurate. If others do mock the client, set limits on this behavior.

- **Consider whether the participant's cognitive problem may require some type of evaluation and possible treatment.** For example, it is possible that a client who is having cognitive difficulty may be experiencing psychotic or prepsychotic symptoms. It is also possible that the client may have a learning disorder. Many clients with learning disabilities already have been evaluated and already may be receiving help. If it appears, however, that an assessment of a client's cognitive difficulties has not been done, the therapist should discuss in supervision the possibility of making such a referral.

If the therapist uses the strategies noted above, inactive participants may be helped to particpate more fully in the group sessions.

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Appendix 1. Therapist Session Reports

A. Individual Session
B. Group Session

MET/CBT5: Therapist Session Report—Individual Session

Site # ____________
Client # ____________
Therapist # ________
Date ______________
Session # __________

Date and time of next scheduled session ____________________________

1) What **topic** was covered in this session?
   1 = MET—Motivation-Building Session
   2 = MET—Goal-Setting Session

2) Other than contacts to schedule appointments, did you have any **additional contacts** with the client (e.g., emergency contacts)?
   1 = Yes
   ___# telephone calls ___total # minutes of telephone contact
   ___# face-to-face contacts ___total # minutes of face-to-face contact

   2 = No

3) To what extent did you **assess the client's use of marijuana** or other substances since the last session (or assessment)?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

4) How does the client's **current marijana use** (since the previous session) compare with his or her use at the initial assessment?
   1 = Client has stopped using marijuana.
   2 = Client has reduced level of marijuana use.
   3 = Client has not changed level of marijuana use.
   4 = Client has increased level of marijuana use.

5) To what extent does the client report use of other illicit substances since the previous session?
   1 = Reports no alcohol or drug (other than marijuana) use.
   2 = Reports other drug use (no alcohol). Type and amount of drug:
   ____
   3 = Reports alcohol use (no other drugs). Amount:
   ____
   4 = Reports alcohol use and other drug use. What drug?
   ____
   9 = Unable to assess.

6) Compared to the first session (or assessment, if this is the first session), how would you describe the client's clinical status at this contact (taking into account his or her current level of substance use, overall mental status, social supports, etc.)?
1 = Poor, deteriorated with respect to treatment inception
2 = Fair, no improvement
3 = Good, some improvement
4 = Very good, significant improvement
5 = Excellent, greatly improved or recovered

7) In your opinion, should this client be considered for removal from treatment?
1 = Yes   2 = No

8) To what extent did you discuss or address the client's **current commitment to abstinence**?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

9) To what extent did you attempt to focus on the client's **ambivalence** about changing his or her level of marijuana use?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

10) To what extent did you attempt to **elicit self-motivational statements** from the client?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

11) To what extent did you encourage the client to make a commitment to change his or her marijuana use?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

12) To what extent did you discuss **high-risk situations** the client encountered since the last session (or assessment, if this was the first session) and explore the coping skills he or she used?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

13) To what extent did you review the **client's reactions** to the last session's assignment?
1....................2............... 3...................4....................5
not at all   a little   somewhat   considerably   extensively

14) Did the client do **the last session's assignment**?
1 = No, no attempt made.
2 = Some attempt made.
3 = Practice exercise completed adequately.
9 = N/A, not assigned.

15) To what extent did you teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing one's social support network, or planning for emergencies and coping with relapse) during the session?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

16) Did you do a **roleplay**?
1 = Yes
2 = No

17) To what extent did you encourage the client to **anticipate any high-risk situations** that might be encountered before the next session and formulate appropriate coping strategies for such situations?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

18) To what extent did you **provide one or more specific assignments** for the client to engage in between sessions?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

19) To what extent did you **emphasize the importance of real life practice** of skills between sessions?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

20) To what extent was it **difficult to engage** the client this session?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

21) To what extent did you attempt to **keep the session focused** on prescribed activities (by redirecting dialog when it strayed off task, and/or organizing the session so defined activities were covered)?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

22) To what extent did you **communicate your understanding** of the client's concerns through reflective listening and comments?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

23) To what extent did you respond to the client with **empathy, warmth, and acceptance**?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

24) To what extent did the client appear **motivated to abstain** from marijuana?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

25) To what extent did the client appear **motivated to reduce** his or her marijuana use?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

26) To what extent did the client report **getting support** from others for abstinence?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

27) To what extent did you discuss the availability and nature of **family support** for the client's efforts in treatment?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

28) To what extent did you **discuss termination** of the therapy (review the timing of termination, encourage the client to discuss his or her feelings or thoughts about termination)?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

Additional Note(s)*:

____

____

____

____

____

________________________ ____________

signature date

* If more space is needed, please continue on the back and note this on the line above.

MET/CBT5: Therapist Session Report—Group Session

Site # ____________
Client # ____________
Therapist # __________
Date ______________
Session # ___________

Date and time of next scheduled session:____________________________

1) What **topic** was covered in this session?
   3 = CBT3—Marijuana Refusal Skills
   4 = CBT4—Enhancing One's Social Support Network
   5 = CBT5—Planning for Emergencies and Coping With Relapse

   1b) If this was Session 4 (CBT4), did you also cover the topic **Increasing Pleasant Activities?**
   1 = Yes
   2 = No

2) To what extent did you **assess clients' use of marijuana** or other substances since the last session (or assessment)?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

3) In your opinion, should any of the clients be considered for **removal from treatment** due to clinical deterioration?
   1 = Yes   If yes, list client #(s): ______________________
   2 = No

4) To what extent did you discuss or address clients' **current commitment to abstinence**?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

5) To what extent did you attempt to **elicit self-motivational statements** from clients?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

6) To what extent did you attempt to focus on clients' **ambivalence** about changing their level of marijuana use?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

7) To what extent did you encourage clients to make a **commitment to change their marijuana use**?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

8) To what extent did you discuss **high-risk situations** clients encountered since the last session (or assessment, if this is the first session) and explore the coping skills they used?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

9) To what extent was it **difficult to engage** the group?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

10) To what extent did you review **clients' reactions** to last session's assignment?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

11) To what extent did you teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing one's social support network, or planning for emergencies and coping with relapse) during the session?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

12) Did you do a **roleplay**?

1 = Yes
2 = No

13) To what extent did you encourage clients to **anticipate high-risk situations** that might be encountered before the next session and formulate appropriate coping strategies for such situations?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

14) To what extent did you **provide one or more specific assignments** for clients to engage in between sessions?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

15) To what extent did you **emphasize the importance of real life practice** of skills between sessions?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

16) To what extent did you attempt to **keep sessions focused** on prescribed activities (by redirecting dialog when it strayed off task and/or organizing the session so defined activities were covered)?

1.....................2................ 3....................4.....................5
not at all a little somewhat considerably extensively

17) To what extent did you **communicate understanding** of clients' concerns through reflective listening and comments?

1.....................2................. 3......................4......................5
not at all a little somewhat considerably extensively

18) To what extent did you respond to clients with **empathy, warmth, and acceptance**?

1.....................2................. 3......................4......................5
not at all a little somewhat considerably extensively

19) To what extent did you discuss the availability and nature of **family support** for clients' efforts in treatment?

1.....................2................. 3......................4......................5
not at all a little somewhat considerably extensively

20) To what extent did you **discuss termination** of the therapy (review the timing of termination; encourage clients to discuss their feelings or thoughts about termination)?

1.....................2................. 3......................4......................5
not at all a little somewhat considerably extensively

Group Report

Client I.D. Number	Attendance	Quantity of Participation	Quality of Participation	Current Marijuana Use*	Other Substance Use**	Clinical Status***	Completion of Assignment	Disruptive Behaviors (list all present)
	P = Present A = Absent L = Late	3 = High 2 = Medium 1 = Low 0 = None	3 = High 2 = Medium 1 = Low 0 = None	9 = Unable to assess 4 = Increased 3 = Unchanged 2 = Reduced 1 = None in the past week	9 = Unable to assess 4 = Alcohol & other drug(s) 3 = Alcohol only 2 = Other drug(s) 1 = None	5 = Excellent 4 = Very Good 3 = Good 2 = Fair, no improvement 1 = Poor, deteriorated	9 = None assigned 3 = Completed 2 = Attempted 1 = No attempt	A = Aggressive I = Interrupts often P = Profanity (excessive) R = Removed (had to be removed from group) S = Sexually inappropriate W = Told war stories O = Other (what?)
Entire Group								

*Current Marijuana Use is the level of use since the previous session in comparison to the level of use at the initial assessment.

** Other Substance Use rates whether any use of alcohol and/or any drug (other than marijuana) occurred since previous session.

***Clinical Status takes into account the current level of substance use, mental status, and overall functioning since the previous session.

Additional Comments: ______________________________

____

Signature

Date

Appendix 2. Supervisor Session Rating Reports

A. Individual Session
B. Group Session

Site # ______________
Client # ____________
Therapist # _________
Date _______________
Session # ___________

1) What **topic** was covered in this session?
   1 = MET—Motivation-Building Session
   2 = MET—Goal-Setting Session

2) To what extent did the therapist **assess the client's use of marijuana** or other substances since the last session (or assessment)?

1	2	3	4	5
not at all	a little	somewhat	considerably	extensively

Skill Level:

0	1	2	3	4	5	6	7
not done	poor			adequate			excellent

3) How does the client's **current marijuana use** (use since the previous session) compare with his or her use at the initial assessment?
   1 = Client has stopped using marijuana.
   2 = Client has reduced his or her level of marijuana use.
   3 = Client has not changed his or her level of marijuana use.
   4 = Client has increased his or her level of marijuana use.

4) To what extent does the client report **use of other illicit substances** since the previous session?
   1 = Reports no alcohol or drug (other than marijuana) use.
   2 = Reports other drug use (no alcohol). Type and amount of drug:
   ____
   3 = Reports alcohol use (no other drugs).
   Amount:_________________________
   4 = Reports alcohol use and other drug use. What drug?
   ____
   9 = Unable to assess.

5) Compared to the first session (or assessment, if this is the first session), how would you describe the client's **clinical status** at this contact (taking into account his or her current level of substance use, overall mental status, social supports, etc.)?
   1 = Poor, deteriorated with respect to treatment inception
   2 = Fair, no improvement
   3 = Good, some improvement
   4 = Very good, significant improvement
   5 = Excellent, greatly improved or recovered

6) In your opinion, should this client be considered for **removal from treatment?**
1 = Yes
2 = No

7) To what extent did the therapist discuss or address the client's **current commitment to abstinence?**
1………………..2……………. 3……………….4…………………5
not at all a little somewhat considerably extensively

Skill Level:
0………1…………..2………..3………….4……….5………..6………..7
not poor adequate excellent
done

8) To what extent did the therapist attempt to focus on the client's **ambivalence** about changing his or her level of marijuana use?
1………………..2……………. 3……………….4…………………5
not at all a little somewhat considerably extensively

Skill Level:
0………1…………..2………..3………….4……….5………..6………..7
not poor adequate excellent
done

9) To what extent did the therapist attempt to **elicit self-motivational statements** from the client?
1………………..2……………. 3……………….4…………………5
not at all a little somewhat considerably extensively

Skill Level:
0………1…………..2………..3………….4……….5………..6………..7
not poor adequate excellent
done

10) To what extent did the therapist encourage the client to make a **commitment to change his or her marijuana use?**
1………………..2……………. 3……………….4…………………5
not at all a little somewhat considerably extensively

Skill Level:
0………1…………..2………..3………….4……….5………..6………..7
not poor adequate excellent
done

11) To what extent did the therapist discuss **high-risk situations** the client encountered since the last session (or assessment, if this is the first session) and explore the coping skills he or she used?
1………………..2……………. 3……………….4…………………5
not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7

not done poor adequate excellent

12) To what extent did the therapist review the **client's reactions** to last session's assignment?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7

not done poor adequate excellent

13) Did the client do the **last session's assignment**?

1 = No, no attempt made.
2 = Some attempt made.
3 = Practice exercise completed adequately.
9 = N/A, not assigned.

14) To what extent did the therapist teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing one's social support network, or planning for emergencies and coping with relapse) during the session?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7

not done poor adequate excellent

15) Did the therapist do a **roleplay**?

1 = Yes
2 = No

Skill Level:

0..........1..............2............3.............4...........5............6............7

not done poor adequate excellent

16) To what extent did the therapist encourage the client to **anticipate any high-risk situations** that might be encountered before the next session and formulate appropriate coping strategies for such situations?

1....................2................ 3...................4.....................5

not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3...........4..........5...........6...........7
not poor adequate excellent
done

17) To what extent did the therapist **provide one or more specific assignments** for the client to engage in between sessions?
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3...........4..........5...........6...........7
not poor adequate excellent
done

18) To what extent did the therapist **emphasize the importance of real life practice** of skills between sessions?
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3...........4..........5...........6...........7
not poor adequate excellent
done

19) To what extent was it **difficult to engage** the client this session?
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

20) To what extent did the therapist attempt to **keep the session focused** on prescribed activities (by redirecting dialog when it strayed off task and/or organizing the session so defined activities were covered)?
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3...........4..........5...........6...........7
not poor adequate excellent
done

21) To what extent did the therapist **communicate understanding** of the client's concerns through reflective listening and comments?
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

22) To what extent did the therapist respond to the client with **empathy, warmth, and acceptance?**
1..................2............... 3..................4...................5
not at all a little somewhat considerably extensively

23) To what extent did the client appear **motivated to abstain** from marijuana?

1....................2................ 3....................4.......................5
not at all a little somewhat considerably extensively

24) To what extent did the client appear **motivated to reduce** his or her marijuana use?

1....................2................ 3....................4.......................5
not at all a little somewhat considerably extensively

25) To what extent did the client report **getting support** for abstinence from others?

1....................2................ 3....................4.......................5
not at all a little somewhat considerably extensively

26) To what extent did the therapist discuss the availability and nature of **family support** for the client's efforts in treatment?

1....................2................ 3....................4.......................5
not at all a little somewhat considerably extensively

27) To what extent did the therapist **discuss termination** of the therapy (review the timing of termination, encourage the client to discuss his or her feelings or thoughts about termination)?

1....................2................ 3....................4.......................5
not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7
not poor adequate excellent
done

Additional Note(s)*: ____

____

____

____

____

* If more space is needed, please continue on the back and note this on the line above.

______________________________ ____________________
Signature Date

MET/CBT5: Supervisor Session Rating—Group Session

Site # ______________
Client # ____________
Therapist # _________
Date ______________
Session # ___________

1) a. What **topic** was covered in this session?
   3 = CBT3—Marijuana Refusal Skills
   4 = CBT4—Enhancing One's Social Support Network
   5 = CBT5—Planning for Emergencies, and Coping With Relapse

   b. If this was session 4 (CBT4), did the therapist also cover the topic **Increasing Pleasant Activities?**
   1 = Yes
   2 = No

2) To what extent did the therapist **assess clients' use of marijuana** or other substances since the last session (or assessment)?
   1....................2................ 3......................4......................5
   not at all a little somewhat considerably extensively

   Skill Level:
   0..........1..............2............3.............4...........5............6............7
   not done poor adequate excellent

3) In your opinion, should any of the clients be considered for **removal from treatment** due to clinical deterioration?
   1 = Yes If yes, list client #(s): ______________________________
   2 = No

4) To what extent did the therapist discuss or address clients' **current commitment to abstinence**?
   1....................2................ 3......................4......................5
   not at all a little somewhat considerably extensively

   Skill Level:
   0..........1..............2............3.............4...........5............6............7
   not done poor adequate excellent

5) To what extent did the therapist attempt to **elicit self-motivational statements** from the clients?
   1....................2................ 3......................4......................5
   not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3............4..........5...........6...........7
not done poor adequate excellent

6) To what extent did the therapist attempt to focus on clients' **ambivalence** about changing their level of marijuana use?
1..................2............... 3..................4....................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3............4..........5...........6...........7
not done poor adequate excellent

7) To what extent did the therapist encourage clients to make a **commitment to change their marijuana use?**
1..................2............... 3..................4....................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3............4..........5...........6...........7
not done poor adequate excellent

8) To what extent did the therapist discuss any **high-risk situations** clients encountered since the last session (or assessment, if this was the first session) and explore any coping skills used?
1..................2............... 3..................4....................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3............4..........5...........6...........7
not done poor adequate excellent

9) To what extent did the therapist review **clients' reactions** to last session's assignment?
1..................2............... 3..................4....................5
not at all a little somewhat considerably extensively

Skill Level:
0.........1.............2...........3............4..........5...........6...........7
not done poor adequate excellent

10) To what extent did the therapist teach, model, rehearse, review, or discuss **specific skills** (e.g., marijuana refusal skills, enhancing one's social support network, or planning for emergencies and coping with relapse) during the session?
1..................2............... 3..................4....................5
not at all a little somewhat considerably extensively

Skill Level:
0..........1..............2............3.............4..........5............6............7
not poor adequate excellent
done

11) Did the therapist do a **roleplay**?
1 = Yes
2 = No

Skill Level:
0..........1..............2............3.............4..........5............6............7
not poor adequate excellent
done

12) To what extent did the therapist encourage clients to **anticipate any high-risk situations** that might be encountered before the next session and formulate appropriate coping strategies for such situations?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level:
0..........1..............2............3.............4..........5............6............7
not poor adequate excellent
done

13) To what extent did the therapist **provide one or more specific assignments** for clients to engage in between sessions?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level:
0..........1..............2............3.............4..........5............6............7
not poor adequate excellent
done

14) To what extent did the therapist **emphasize the importance of real life practice** of skills between sessions?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level:
0..........1..............2............3.............4..........5............6............7
not poor adequate excellent
done

15) To what extent was it **difficult to engage** the group?
1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

16) To what extent did group members present **behaviors that were disruptive to the group process** (e.g., aggression, war stories, excessive profanity)?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level (of therapist's management of disruptive behaviors within this group):

0..........1..............2............3.............4...........5............6............7
not done poor adequate excellent

17) To what extent did the therapist attempt to **keep the session focused** on prescribed activities (by redirecting dialog when it strayed off task and/or organizing the session so that defined activities were covered)?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7
not done poor adequate excellent

18) To what extent did the therapist **communicate understanding** of clients' concerns through reflective listening and comments?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

19) To what extent did the therapist respond to clients with **empathy, warmth, and acceptance**?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

20) To what extent did the therapist discuss the availability and nature of **family support** for clients' efforts in treatment?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

21) To what extent did the therapist **discuss termination** of the therapy (review the timing of termination; encourage clients to discuss their feelings or thoughts about termination)?

1....................2................ 3....................4......................5
not at all a little somewhat considerably extensively

Skill Level:

0..........1..............2............3.............4...........5............6............7
not done poor adequate excellent

- Rate the **quantity of participation** of this group.
    - 3 = High
    - 2 = Medium
    - 1 = Low
    - 0 = Silent
- Rate the **quality of participation** of this group.
    - 3 = High
    - 2 = Medium
    - 1 = Low
    - 0 = None

Additional Note(s)*: ____
____
____
____
____

* If more space is needed, please continue on the back and note this on the line above.

______________________________ ____________________
Signature Date

Appendix 3. Facsimiles of 11- by 17-inch Posters for Sessions 3, 4, and 5

A. Session 3
B. Session 4
C. Session 5

SESSION 3

MARIJUANA REFUSAL SKILLS

Why?

- Immediate, effective response is needed when someone is pressured to use marijuana.
- One's social circle narrows with increased marijuana use.
- It's best, but not always possible, to avoid high-risk people and situations.

SKILL GUIDELINES

Nonverbal Behaviors:

- Speak in a clear, firm voice.
- Make eye contact.
- Don't feel guilty about refusing marijuana.

Verbal Behaviors:

- "No" should be your first word.
- Suggest something fun and safe to do instead.
- Change the subject.
- Avoid excuses or vague answers.
- If pressure continues, ask him or her to stop asking you to use.

Session 4

ENHANCING ONE'S SOCIAL SUPPORT NETWORK

WHY?

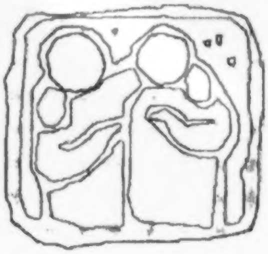
- When people try to quit marijuana, support helps them succeed.
- People often don't have as much support as they'd like.

Skill Guidelines

WHO might provide good support?

- Consider family, friends, acquaintances, others in your community.
- Someone who is usually supportive.
- Someone who is usually neutral.
- Someone who might become supportive.

WHAT kinds of support can you ask for?



- Help with problem solving.
- Information.
- Moral support.
- Sharing the load.
- Emergency help.

HOW can you get the support you need?

- Ask for what you need.
- Add new supporters.
- Lend your support to others.
- Give your supporters feedback.

SESSION 5

PLANNING FOR EMERGENCIES AND COPING WITH RELAPSE

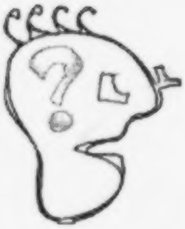
Why?

- Preparation for an emergency increases good coping skills.
- Problem solving is a way to cope.
- Emergencies and relapses are learning opportunities.

SKILL GUIDELINES

Types of Possible Emergencies:

- An unanticipated marijuana trigger.
- Separation from an important person in your life.
- School problems.
- Adjustment to a new life situation or new responsibilities.



Steps for Problem Solving

Recognize that a problem exists.

1. Identify the problem. Think: What is the problem?
2. Consider various approaches (brainstorm): What can I do?
3. Think ahead to the good and bad that may come out of each possible approach.
4. Choose one, and do it. Evaluate the outcome: Did this work for me?

Appendix 4. Personalized Feedback Reports

A. With Instructions for Compiling
B. Without Instructions (for use in therapy)

Therapist ____________
Client ____________

Personalized Feedback Report (PFR) Instructions

The personalized feedback report is used to summarize information the client reported in the intake assessment for use in a feedback session. Below is a copy of the PFR (in regular text) that has been supplemented with instructions on how to complete it (in bold italic). A copy of GAIN and the Reasons for Quitting Questionnaire (RFQ) from the Supplemental Assessment Form (SAF) are available at www.chestnut.org/li/cyt/ or www.chestnut.org/li/cyt/products/index.html. They are followed by tables required for calculating the percentiles and a clean copy of the PFR with no instructions.

This report summarizes some of the information that you gave us in your interview on ___/___/___ ***(record date of baseline interview [XOBSDT,] from global appraisal of individual needs-initial (GAIN-I)—bottom of cover page).***

We want to give you an opportunity to review what you've told us and make any changes or additions. As you and I work together in reviewing and discussing this specific personal information, we can help you develop strategies for dealing with marijuana that fit your individual needs.

Primary Substances

You reported that your favorite substance to use was _____ and that you needed treatment for ________________________________ ***(get from GAIN, page 12, S1a and S1b).*** You told us you first used alcohol or drugs at age ____ (***use age of first use, GAIN, page 22, S9v)*** and have been smoking marijuana for ____ years ***(use current age - age of first use, GAIN, page 23, Row v, Column 3).*** In the past year, you told us you had used ______________________________ ***(record all substances with 6-2 circled on GAIN, page 13, S2a1-99).*** You have been in substance treatment ____ times before ***(GAIN, page 18, S7).***

Extent of Use

In the past 90 days, you smoked marijuana on _____ of those days, with the heaviest use being ____ joints/pipes over a ___ hour period ***(use information from GAIN, page 14, questions S2f1–S2f3).*** This places you in the _____ percentile ***(use Table 1)*** relative to other adolescents age ____ to ____ in America ***(round percentile to nearest integer).***

In the past 90 days, you drank alcohol on _____ of those days, with the heaviest drinking episode being ____ drinks over a ___ hour period ***(use information from GAIN, page 14, questions S2e1–S2e3).*** This places you in the _____ percentile ***(use Table 2)*** relative to other adolescents age ____ to ____ in America **(round percentile to nearest integer).**

In the past 90 days, you reported that you used other drugs, including ______________________, on ___ days ***(use GAIN, page14, S2g1).*** In the past week you reported that you (had/had not) tried to quit using drugs and/or alcohol (and that when you did you had the following problems: ______________________ ***(use GAIN, page 16, S3).*** *[List only items that the client endorsed. List could include moving and talking much slower than usual **(1)**; yawning more than usual **(2)**; feeling tired **(3)**; having bad dreams that seem real **(4)**; having trouble sleeping (sleeping too much or trouble staying asleep) **(5)**; feeling sad, tense, or angry **(6)**; feeling really nervous or tense **(7)**; fidgeting, pacing, wringing your hands, or trouble sitting still **(8)**; having shaky hands **(9)**; having convulsions or seizures **(10)**; feeling hungrier than usual **(11)**; throwing up or feeling like throwing up **(12)**; having diarrhea **(13)**; having muscle aches **(14)**; having a runny nose or eyes watering more than usual **(15)**; sweating more than usual, having your heart race or goose bumps **(16)**; having a fever **(17)**; seeing, feeling, or hearing things that are not real **(18)**; forgetting a list of things or having problems remembering **(19)**; withdrawal symptoms prevented you from doing usual activities **(20)**; starting to use again to avoid withdrawal symptoms **(21)**; other: ________________________ **(99)**.*

Problems
You indicated that your use of marijuana, alcohol, and/or other substances had caused you the following kinds of problems ***(list only problems endorsed on GAIN, page 23, S9 or PSF, page 2, PS9):***

- ☐ You did not meet your responsibilities at home, school, or work ***(h)***
- ☐ You used in situations where it was unsafe for you (driving a car, using a machine, or where you might have been hurt or forced into sex) ***(j)***
- ☐ Using caused you to have problems with the law **(k)**
- ☐ You kept using even though it was causing you to get into fights (or other kinds of legal trouble) ***(m)***
- ☐ You had to use more to get the same high (or found the same amount did not get you as high as it used to) ***(n)***
- ☐ You had withdrawal symptoms when you tried to stop (or used to stop being sick or avoid withdrawal problems) ***(p)***
- ☐ You used for longer than you meant to ***(q)***
- ☐ You have been unable to cut down or stop using ***(r)***
- ☐ You spent a lot of time getting or using marijuana, alcohol, or other substances (or feeling the effects of alcohol or drugs—high, sick) ***(s)***
- ☐ Using caused you to give up, reduce, or have problems at important activities at home, school, work, or social events ***(t)***
- ☐ You have kept using despite medical or psychological problems ***(u)***

As you reflect on the consequences of smoking marijuana on your life, what would you add?

____

____

Reasons for Quitting

You said the main reason you came to treatment was ____________________ ***(use GAIN, Page 6, A4a).*** We showed you a list of personal reasons for quitting marijuana, and you also said you wanted to quit ***(list only the items below that the client endorsed. Use RFQ questionnaire in SAF, pages 6-8, and list items coded 2, 3, or 4. Also add any open-ended items listed by the client in question 27 that are not included in the list).***

☐ To show myself that I can quit if I really want to (E1)
☐ To like myself better ***(E2)***
☐ So that I won't have to leave social functions or other people's houses ***(E3)***
☐ To feel in control of my life ***(E4)***
☐ So that my parents, girlfriend, boyfriend, or another person I am close to will stop nagging me ***(E5)***
☐ To get praise from people I am close to ***(E6)***
☐ Because smoking marijuana does not fit in with my self-image ***(E7)***
☐ Because smoking marijuana is less cool or socially acceptable ***(E8)***
☐ Because someone has given me an ultimatum ***(E9)***
☐ So that I will receive a special gift ***(E10)***
☐ Because of potential health problems ***(E11)***
☐ Because people I am close to will be upset if I don't ***(E12)***
☐ So that I can get more things done during the day ***(E13)***
☐ Because marijuana use is hurting my health ***(E14)***
☐ Because I will save money by quitting ***(E15)***
☐ To prove I'm not addicted ***(E16)***
☐ Because there is a drug testing policy in detention, probation, parole, or school ***(E17)***
☐ Because I know others with health problems caused by marijuana ***(E18)***
☐ Because I am concerned that smoking marijuana will shorten my life ***(E19)***
☐ Because of legal problems related to my use ***(E20)***
☐ Because I don't want to embarrass my family ***(E21)***
☐ So that I will have more energy ***(E22)***
☐ So my hair and clothes won't smell like marijuana ***(E23)***
☐ So I won't burn holes in clothes or furniture ***(E24)***
☐ Because my memory will improve ***(E25)***
☐ So that I will be able to think more clearly ***(E26)***

You listed these because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?

____

____

You also told us about several other problems that might be caused or made worse by your marijuana, alcohol, or other drug use. These include *(list only those that apply).*

- ☐ The health problems you reported ***(use if 1+ days in GAIN, page 28, P9a).***
- ☐ The emotional problems you reported ***(use if 1+ days in GAIN, page 37, M1f).***
- ☐ Being bothered by upsetting memories ***(use if 1+ days in GAIN, page 38, M2q).***
- ☐ Having problems paying attention or controlling your behavior ***(use if 1+ days in GAIN, page 40, M3c).***
- ☐ The family problems you reported ***(use if 1+ days in GAIN, page 46, E3).***
- ☐ Arguments and problems you had with your temper ***(use if 1+ days in GAIN, page 50, E8p).***
- ☐ Being physically, sexually, or emotionally hurt ***(use if 1+ days in GAIN, page 52, E9u).***
- ☐ Doing things that were illegal ***(use if 1+ days in GAIN, page 58, L3v).***
- ☐ Getting in trouble at school ***(use if 1+ days in GAIN, page 64, V3p or V3q).***
- ☐ Getting in trouble at work ***(use if 1+ days in GAIN, page 67, V6p or V6q).***

Pattern of Use

You told us that the place(s) where you typically use marijuana, alcohol, and other drugs is/are ***(use GAIN, page 15, S2h).***

- ☐ at home
- ☐ at someone else's home
- ☐ at a party/bar
- ☐ at work
- ☐ at school
- ☐ at a dealer's house
- ☐ outdoors
- ☐ in a car
- ☐ somewhere else (________________________)

and that you typically use it with ***(use GAIN, page 15, S2j):***

- ☐ no one else, alone
- ☐ your romantic/sexual partner
- ☐ family
- ☐ friends
- ☐ a club or gang
- ☐ coworkers
- ☐ classmates
- ☐ a running partner (someone you regularly do drugs with)
- ☐ drug dealer/pusher
- ☐ someone else (________________)

As you think about highly tempting situations, are there situations that you'd like to add?

____

____

Situational Confidence
You told us you thought you could avoid using alcohol or drugs at ***(use GAIN, Page 20, S8m–q)***.

☐ home
☐ school or work
☐ with your friends
☐ when everyone around you was using them

You also told us that you (had quit and were _____% sure you could stay abstinent/had not quit yet but were ____% sure you could quit) ***(use SAF, page 8, E28)***.

Table 1: Days of Marijuana Use From Community Sample of 5,143 Adolescents From the 1995 National Household Survey on Drug Abuse

Rate	12-13 Years	14-16 Years	17-18 Years
None	98%	90%	86%
Monthly	99%	95%	94%
Weekly	100%	97%	96%
Daily	100%	100%	100%

Rate for NHSDA during the past 30 days is defined as follows: None = 0 days, Monthly = 1-4 days, Weekly = 5-14 days, Daily = 15-30 days; For CYT, during the past 90 days: None= 0 days, Monthly = 1-12 days, Weekly = 13-44 days, Daily = 45-90 days (Office of Applied Studies, 1997).

Table 2: Days of Alcohol Use From Community Sample of 5,143 Adolescents From National Household Survey on Drug Abuse

Rate	12-13 Years	14-16 Years	17-18 Years
None	92%	75%	58%
Monthly	96%	89%	83%
Weekly	97%	93%	92%
Daily	100%	100%	100%

Rate for NHSDA during the past 30 days is defined as follows: None = 0 days, Monthly = 1-4 days, Weekly = 5-14 days, Daily = 15-30 days; For CYT, during the past 90 days: None= 0 days, Monthly = 1-12 days, Weekly = 13-44 days, Daily = 45-90 days (Office of Applied Studies, 1997).

Therapist ________________
Client ________________

Personalized Feedback Report (PFR)

This report summarizes some of the information that you gave us in your interview on ____/____/_____.

We want to give you an opportunity to review what you've told us and make any changes or additions. As you and I work together in reviewing and discussing this specific personal information, we can help you develop a program and strategies for dealing with marijuana that fit your individual needs.

Primary Substances
You reported that your favorite substance to use was ___________________ and that you that you needed treatment for ______________________________. You told us you first used alcohol or drugs at age ___ and have been smoking marijuana for ____ years. In the past year you told us you had used _________________________. You have been in substance treatment ____ times before.

Extent of Use
In the past 90 days, you smoked marijuana on _____ of those days, with the heaviest use being ____ joints/pipes over a ___ hour period. This places you in the _____ percentile relative to other adolescents in America age ___ to ___.

In the past 90 days, you drank alcohol on _____ of those days, with the heaviest drinking episode being ____ drinks over a ___ hour period. This places you in the _____ percentile relative to other adolescents in America age ___ to ___ .

In the past 90 days, you reported that you used other drugs, including _________________________, on ___ days. In the past week you reported that you (had/had not) tried to quit using drugs and/or alcohol (and that when you did you had the following problems:____)
[List only the items that the client endorsed. List could include moving and talking much slower than usual; yawning more than usual; feeling tired; having bad dreams that seem real; having trouble sleeping (sleeping too much or trouble staying asleep); feeling sad, tense, or angry; feeling really nervous or tense; fidgeting, pacing, wringing your hands, or trouble sitting still; having shaky hands; having convulsions or seizures; feeling hungrier than usual; throwing up or feeling like throwing up; having diarrhea; having muscle aches; having a runny nose or eyes watering more than usual; sweating more than usual, having your heart race or goose bumps; having a fever; seeing, feeling, or hearing things that are not real; forgetting a list of things or having problems remembering; withdrawal symptoms that prevented you from doing your usual activities; starting to use again to avoid withdrawal symptoms; other: _____________________].

Problems

You indicated that your use of marijuana, alcohol, and/or other substances had caused you the following kinds of problems:

- ☐ You did not meet your responsibilities at home, school, or work.
- ☐ You used in situations where it was unsafe for you (driving a car, using a machine, or where you might have been hurt or forced into sex).
- ☐ Using caused you to have problems with the law.
- ☐ You kept using even though it was causing you to get into fights (or other kinds of legal trouble).
- ☐ You had to use more to get the same high (or found the same amount did not get you as high as it used to).
- ☐ You had withdrawal symptoms when you tried to stop (or used to stop being sick or avoid withdrawal problems).
- ☐ You used for longer than you meant to.
- ☐ You have been unable to cut down or stop using.
- ☐ You spent a lot of time getting or using marijuana, alcohol, or other substances (or feeling the effects of alcohol or drugs—high, sick).
- ☐ Using caused you to give up, reduce, or have problems at important activities at home, school, work, or social events.
- ☐ You have kept using despite medical or psychological problems.

As you reflect on the consequences of smoking marijuana on your life, what would you add?

____

____

Reasons for Quitting

You said the main reason you came to treatment was ________________. We showed you a list of personal reasons for quitting marijuana, and you said that you wanted to quit:

- ☐ To show myself that I can quit if I really want to.
- ☐ To like myself better.
- ☐ So that I won't have to leave social functions or other people's houses.
- ☐ To feel in control of my life.
- ☐ So that my parents, girlfriend, boyfriend, or another person I am close to will stop nagging me.
- ☐ To get praise from people I am close to.
- ☐ Because smoking marijuana does not fit in with my self-image.
- ☐ Because smoking marijuana is less socially acceptable.
- ☐ Because someone has given me an ultimatum.
- ☐ So that I will receive a special gift.
- ☐ Because of potential health problems.
- ☐ Because people I am close to will be upset if I don't.
- ☐ So that I can get more things done during the day.
- ☐ Because marijuana use is hurting my health.
- ☐ Because I will save money by quitting.
- ☐ To prove I'm not addicted.
- ☐ Because there is a drug testing policy in detention, probation, parole, or school.
- ☐ Because I know others with health problems caused by marijuana.

☐ Because I am concerned that smoking marijuana will shorten my life.
☐ Because of legal problems related to my use.
☐ Because I don't want to embarrass my family.
☐ So that I will have more energy.
☐ So my hair and clothes won't smell like marijuana.
☐ So I won't burn holes in clothes or furniture.
☐ Because my memory will improve.
☐ So that I will be able to think more clearly.

You listed these because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?

____

____

You also told us about several other problems that might be caused or made worse by your marijuana, alcohol, or other drug use. These include:

☐ The health problems you reported.
☐ The emotional problems you reported.
☐ Being bothered by upsetting memories.
☐ Having problems paying attention or controlling your behavior.
☐ The family problems you reported.
☐ Arguments and problems you had with your temper.
☐ Being physically, sexually, or emotionally hurt.
☐ Doing things that were illegal.
☐ Getting in trouble at school.
☐ Getting in trouble at work.

Pattern of Use

You told us that the place(s) where you typically use marijuana, alcohol, and other drugs is/are:

☐ at home
☐ at someone else's home
☐ at a party/bar
☐ at work
☐ at school
☐ at a dealer's house
☐ outdoors
☐ in a car
☐ somewhere else (__________________________)

and that you typically use it with:

☐ no one else, alone
☐ your romantic/sexual partner
☐ family
☐ friends
☐ a club or gang
☐ coworkers
☐ classmates
☐ a running partner (someone you regularly do drugs with)

- ☐ a drug dealer/pusher
- ☐ someone else (______________________)

As you think about highly tempting situations, are there situations that you'd like to add?

____

____

Situational Confidence

You told us you thought you could avoid using alcohol or drugs at:

- ☐ home
- ☐ school or work
- ☐ with your friends
- ☐ when everyone around you was using them

You also told us that you (had quit and were ____% sure you could stay abstinent/had not quit yet but were ____% sure you could quit).

Appendix 5. Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abuse

The Clinical Management of a Multisite Field Trial of Five Outpatient Treatments for Adolescent Substance Abuse

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Abstract

Bridging the gap between clinical research and clinical practice in the treatment of adolescent substance abuse requires empirically validated therapies and technology transfer strategies that reflect an awareness of the realities and resource constraints of local treatment service providers. This article describes the management of cross-site and cross-intervention clinical issues in the Cannabis Youth Treatment (CYT) study, a multisite, randomized, clinical trial of five outpatient therapies. The methods used in the management of such clinical trials could play an important role in elevating the quality of adolescent substance abuse treatment as practiced in the field. This technology involves: 1) defining and delineating clinically relevant subpopulations of clients, 2) developing research-supported manuals that define the theory, active ingredients, and procedures of treatment, 3) monitoring therapist adherence to manual-based therapy, 4) monitoring client responses to the procedures as they are implemented, 5) individualizing and refining the delivery of these manual-based therapies within the context of clinical supervision, and 6) conducting rigorous and sustained followup to determine the enduring effects of the interventions.

Carrol and her colleagues (1994) detailed the strategies used to implement and to protect the integrity of three manual-based therapies evaluated within Project MATCH, a multisite study of adult alcoholism treatment (Project MATCH Research Group, 1993). This paper takes a similar approach in describing cross-site clinical coordination procedures within the Cannabis Youth Treatment study, the largest multisite, randomized field experiment ever conducted of adolescent substance abuse treatment. More specifically, the paper details the common clinical infrastructure within which these therapies were implemented across the treatment sites.

It is our collective experience that therapies can fail in the transition from efficacy (outcomes under ideal circumstances) to effectiveness (outcomes in the real world of adolescent treatment), not because of flaws in the interventions themselves, but because of the absence of a sound foundation of clinical management upon which empirically validated interventions are replicated. The construction of stable clinical infrastructures within local treatment programs is as important to the future of adolescent treatment as the availability of research-validated therapies.

After declining in the 1980s, both licit and illicit drug use among adolescents rose in the 1990s. In 1996, cannabis use by adolescents (8th, 10th, and 12th graders) reached its highest peak in 12 years for reported lifetime use, past year use, and past month use (ISR, 1997). As cannabis abuse/dependence emerged as the leading cause for admission to substance abuse treatment (OAS, 1997), demands increased for research-validated treatments for cannabis-involved adolescents. In response to this need, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) of the Department of Health and Human Services (DHHS) funded the CYT study.

The CYT study is a multisite, randomized field experiment designed to test the efficacy of five promising outpatient treatment interventions for cannabis-abusing and cannabis-dependent adolescents. Its long-range goal is to provide validated and cost-effective models of intervention that can be widely replicated in local treatment agencies across the country. The study sites include Chestnut Health Systems in Madison County, Illinois (CHS–MC); the University of Connecticut Health Center (UCHC) in Farmington, Connecticut; Operation PAR in St. Petersburg, Florida (PAR); and the Children's Hospital of Philadelphia (CHOP) in Pennsylvania. The sites represent both academic, research-oriented clinics (UCHC and CHOP) and community-based adolescent treatment programs (CHS–MC and PAR) (Dennis, Babor, Diamond, Donaldson, Goldley, Tims, et al., 1998; Herrell, Babor, Brantley, Dennis, et. al., 1999). The CYT study provides a test in geographically diverse environments of treatments that differ in theoretical orientation, delivery format and focus, and dose.

Between June 1998 and February 1999, 600 adolescents (approximately 150 per site) meeting the *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition-Revised (DSM–IV) criteria (American Psychiatric Association, 1994) for cannabis abuse or cannabis dependence were randomly assigned to one of three conditions, with a total of five conditions used across the four sites. The five conditions include:

- Motivational Enhancement Treatment/Cognitive Behavior Treatment—5 individual/group sessions (MET/CBT5) (Sampl & Kadden, 2001)
- Motivational Enhancement Treatment/Cognitive Behavior Treatment—12 individual/group sessions (MET/CBT12) (Webb, Scudder, Kaminer, & Kadden, in press)
- Family Support Network (FSN) (Hamilton, Brantley, Tims, Angelovich, N., & McDougall, in press) (FSN includes MET/CBT12 plus enhanced family supports: home visits, parent education classes, parent support groups)

- Adolescent Community Reinforcement Approach (ACRA) (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, in press)

- Multidimensional Family Therapy (MDFT) (Liddle, in press)

At UCHC and PAR, adolescents were assigned to a five-session brief intervention (MET/CBT5) or to one of two other interventions that combine more extensive individual and group sessions (MET/CBT12 or FSN). At CHS-MC and CHOP, adolescents were assigned to the five-session brief intervention (MET/CBT5) or to one of two individual/family approaches (ACRA or MDFT). All study participants were assessed at intake and at 3 months, 6 months, 9 months, and 12 months. Treatment completion rates were in the 70-percent range, and followup rates through 9 months after treatment exceeded 95 percent (Titus et al., 1999; Godley, Diamond & Liddle, 1999).

Methodological Challenges

There were three important challenges in conducting this multisite field experiment. The first was to ensure the integrity of each of the interventions being tested (Moncher & Prinz, 1991). Following what has been referred to as the "technology model" (Carroll et al., 1994; Carroll & Nuro, 1996; Carroll, 1997), workgroups led by a technical expert in interventions and a therapist coordinator (TC) responsible for cross-site supervision of that intervention took the following six steps to enhance its integrity:

- Defined and manualized the active ingredients of each therapy, including the frequency, intensity, duration, sequencing, and indicated responses to the most common problems that occur during delivery of the intervention

- Conducted 15 to 25 hours of centralized, competency-based training (15 to 25 hours) for the therapists delivering the interventions and followed this by local certification of staff in each intervention

- Developed a therapist's skillfulness scale to serve as a cross-site measure of general therapeutic competence

- Developed a service contact log to measure therapists' adherence to each of the five interventions and to document the dosage and types of services provided to each client

- Taped and rated sessions for model fidelity (all tapes were rated as part of the cross-site supervision by an expert in the intervention until each therapist was certified, after which two tapes per therapist, per month, were reviewed and rated)

- Conducted weekly (1-hour onsite or telephone) individual supervision and weekly or bimonthly (60 to 90 minute) cross-site group supervision for each intervention.

These procedures helped enhance treatment differentiability (the delineation of the ingredients and procedures that distinguished each treatment from the other treatments) and treatment adherence (the ensurance that the interventions [as delivered] maintained fidelity to the original manual-defined procedures) (Hoffart, 1994).

A second challenge involved controlling extraneous factors that could compromise interpretation of the treatment outcomes. To accomplish this, every effort was made to ensure that all general clinical procedures, other than those involved in the specific therapies, would be handled similarly across sites and interventions. This was done to minimize the ability of these contextual issues to unduly influence the evaluation of the experimental interventions and was achieved in two ways. First, staff of the CYT coordinating center conducted two site visits at each of the four service delivery sites to ensure that each site met baseline standards related to arenas such as research protocol compliance, accessibility and appropriateness of clinical space, clinical supervision structure, recruitment strategies, intake and service procedures, confidentiality procedures, crisis and safety net procedures, clinical documentation, data security and storage, and followup procedures. Second, the TCs for each intervention coordinated similar responses to issues that were not part of the specific interventions in monthly conference calls facilitated by the CYT coordinating center. Details of this latter process will be described shortly.

The third challenge was to enhance the external validity of the interventions (the generalizability of study findings) by ensuring that the interventions could be implemented as designed within the resource constraints of settings that currently provide the bulk of services to drug-involved adolescents. It was the goal of the CYT TCs to do everything possible in the CYT study to bridge the traditional gap between efficacy research conducted under experimental (ideal) conditions and effectiveness research conducted in field (real) settings. We wanted to document the kind of clinical infrastructures and the management of day-to-day clinical issues that might need to accompany these unique interventions if they were to achieve comparable results in the field.

The monthly conference calls among the TCs for each of the five interventions and the staff from the CYT coordinating center were particularly helpful in facing the latter two of these challenges. The purpose of these meetings was to define how sites would manage common clinical issues that were not a unique part of the experimental interventions but which, if not identified and controlled, might corrupt the evaluation of these interventions. We were concerned, for example, that if therapists in one intervention expelled adolescents from treatment (and the study) for arriving at a session high, while another site either allowed such adolescents to participate or rescheduled their sessions, differences in completion rates between these sites would reflect not the power or weakness of the interventions but contextual policies unrelated to the active ingredients of each intervention.

What follows is a synopsis of how common clinical issues were managed across the four treatment sites and across the five interventions being tested. It is hoped that this discussion will provide researchers and treatment practitioners alike with insights into the importance of managing such contextual influences. The discussion also represents a snapshot of baseline clinical practices in adolescent substance abuse treatment in 1998 and 1999.

Issues in Clinical Management and Clinical Care

A. Clinical Infrastructure. A rather complex clinical infrastructure was required to effectively manage clinical activities across the four treatment organizations and the five treatments in the CYT study. The care taken in constructing this infrastructure was based on the assumption that there is a close relationship between the quality of clinical supervision and treatment efficacy (Holloway & Neufeldt, 1995).

There were three levels of clinical coordination and supervision in the CYT study. First, local clinical supervisors at each service site coordinated cross-intervention clinical issues and day-to-day clinical problem solving. Second, a therapist coordinator for each of the five interventions used in the CYT study provided onsite and cross-site clinical supervision of staff working in their particular intervention. This supervision occurred weekly during the period in which therapists were being certified, and bimonthly following staff certification. Third, a TC at the CYT coordinating center facilitated cross-site and cross-intervention coordination and problem solving. The centerpiece of this cross-site clinical coordination was a monthly meeting at which the respective TCs met with the cross-site TC and research coordinator via conference call to discuss cross-site clinical and research issues. Particular problems or procedural questions emerging from these discussions were sometimes also referred to the CYT executive committee (all of the principal investigators and the CSAT project officer and other CSAT staff) for consultation or decision making. The CYT coordinating center validated that the cross-site clinical procedures developed through these processes were in place by conducting two monitoring visits to each of the CYT research sites during the course of the study (*CYT Site Visit Protocol*, 1999).

Many problems and issues (administrative, fiscal, research, clinical, ethical, legal) were addressed in this multitiered supervisory structure, but the major goals were to meet the methodological challenges noted earlier: ensuring the integrity of the interventions, controlling factors that could confound outcomes, and enhancing the generalizability of findings. Several steps were taken to achieve these goals.

All sites used the same research and service intake and clinical assessment/screening procedures, the same inclusion and exclusion criteria, and the same approach to randomization and waiting list management. To maximize transferability of findings to the field, exclusion criteria were limited to adolescents 1) who needed a higher level of care than outpatient treatment, 2) who presented for treatment with confirmed histories of drug dealing or violence (particularly predatory behavior patterns reflecting a high frequency, high intensity, and long duration), 3) whose psychiatric comorbidity was so severe as to render them inappropriate for the CYT interventions, and 4) whose primary drug of choice was not cannabis. Although the study focused on adolescents with a primary drug choice of cannabis, most adolescents entering the CYT study reported using other drugs in addition to cannabis. Although abstinence from all alcohol and other drug use was a goal of the treatments in the CYT study, at admission, adolescents were asked to agree to evaluate their drug use and its effects on themselves and their families. Therapists across sites and interventions agreed that many adolescents' commitment to abstinence was something that should emerge out of the treatment process, not something that should be a precondition for entry into treatment.

Mechanisms to enhance clinical fidelity to the interventions used in the study included centralized training and booster training of clinical staff delivering the interventions, the videotaping or audiotaping of all sessions followed by the use of self- and supervisory-scored adherence measures to monitor skillful execution of the intervention, formal procedures to certify each therapist in the intervention, continued postcertification tape reviews to minimize therapist "drift," and regular cross-site group supervision led by an expert in the intervention.

A considerable portion of the monthly meeting of the CYT TCs was aimed at ensuring baseline clinical processes and data collection procedures were being handled consistently across the four sites. There were discussions of just about everything—from drug testing procedures to appropriate responses to clinical deterioration of a study participant. The monthly agenda included a site-by-site review of particular issues, such as the status of therapists' certifications and the quality of communication between sister sites (those delivering the same interventions) and an opportunity to discuss the general problems and issues encountered. Below are some of the cross-site clinical issues that were of major concern throughout the course of the study.

B. Staff Recruitment, Training, and Retention. Most of the therapists working on the CYT project were trained at the master's degree level or higher, and most had prior training and experience in addiction treatment. The research sites, like the practice field, varied in their use of full-time and part-time staff. Most sites felt there were advantages to having full-time therapists working on the project because that increased their availability to clients, provided greater flexibility in scheduling, and created a greater degree of personal investment in the project. In general, sites looked for individuals with good clinical skills whose overall clinical orientations were congruent with the intervention they were going to deliver. A particular effort was made to find staff who had a good working knowledge of child and adolescent development—a qualification not often found in those working with adolescent substance abusers (Kaminer, 1994).

Staff were paid salaries that were at or slightly above the geographical norm for addiction therapists. None of the sites experienced any significant problems recruiting qualified staff.

In the course of the project, there were a total of 26 full-time and part-time clinical positions at the four CYT sites. Nine staff left the CYT project during this period—two due to changes in the communities selected as service sites and the majority of the others due to either a return to school, family relocation, or promotion. The highest turnover rate was among the case managers. Several things worked to enhance staff morale and retention on the CYT project: a conscious effort to build team cohesion, a knowledge of the potential importance of the research being conducted, the training and supervision opportunities, the opportunity for cross-site contact with peers working on the same intervention, and the flexibility of the individual sites regarding scheduling of part-time employees on the project.

Although considerable effort is made to ensure that conditions in clinical trials are equivalent to natural conditions in the field, there are several characteristics of clinical trials staff that make them somewhat different from those in mainstream practice. Staff who seek clinical positions in clinical trials are not scared away by the limited timeframe of employment on such a project, are often attracted by the intense nature of training and supervision such projects afford, and are not put off by the rigorous record-keeping generally required in such projects.

Strategies used for managing clinical continuity in the face of staff attrition included replicating the training that was provided to all therapists at the beginning of the CYT project, having a built-in transition/training period for entering staff, and using videotaped sessions of the current therapists to train new therapists.

The safety of staff working in the field was enhanced by hiring staff from the local community; providing inservice training on safety management and access to beepers and cellular phones; and the option of working in teams to visit areas that posed higher safety threats. Office-based safety issues were addressed by ensuring that other staff were present while sessions were being conducted and by providing walkie-talkies or silent alarms to signal other staff if assistance was needed. There were no major safety-related incidents experienced by the CYT project.

C. Client/Family Recruitment, Engagement, and Retention. The major barriers in recruiting, engaging, and retaining adolescents and their families were fairly consistent across the CYT project sites:

- Low adolescent/parent motivation for treatment involvement
- The perception that other problems in the family were more important than the drug experimentation of one child
- Parental substance abuse

- The parental view that smoking marijuana is not that big a deal
- Failure to attend due to lack of transportation or childcare
- A marital or relationship breakup during the period of treatment involvement
- Inconsistent messages from the parents to the adolescent about the importance of involvement in counseling
- Relocation of the child during the course of treatment
- Parents having given up on efforts to change their child
- A general and pervasive sense of hopelessness about life (both the parents and the adolescent).

Study participants were recruited by direct appeals to youth and parents through newspaper and radio public service announcements and strategically placed bulletin board posters. Staff also oriented local youth service professionals regarding how referrals could be made to the program and the nature of the various treatments that youth would be receiving. These visits and mailings included CYT information packets, business cards, and Rolodex inserts. There was some resistance to referring clients to the project when referral sources discovered that they could not control which intervention their clients would receive. Some were concerned that the five-session intervention would not provide an adequate level of service. After some education about the benefits of brief therapy in general, however, and the need to test such therapies in the substance abuse arena, most were willing to make referrals.

Of 690 adolescents referred to the CYT sites between May 1, 1998, and May 31, 1999, 38.6 percent were referred by criminal justice-affiliated agencies, 24.8 percent by families (7.6 percent of which came from a media promotion of the CYT project), and 15.2 percent by educational community health and human service agencies (Webb & Babor, 1999). An analysis of adolescents admitted to treatment in the CYT study (Tims, Hamilton, Dennis, & Brantley, 1999) revealed that 84.7 percent were age 15 or older, 38.1 percent were nonwhite, and 11.9 percent were female. The low rate of female admissions is attributable to at least two factors. The first involves the use of referral sources such as juvenile probation departments that serve predominantly male clients. The second factor is that of those females referred to the CYT study, more than one-third presented with comorbid psychiatric disorders severe enough to exclude their participation in the study.

Client engagement was enhanced through five broad strategies. The first was to make the transition between the research staff (the equivalent of the intake staff in most agencies) and the clinical staff as personal as possible. When therapists were not available to be introduced to the client/family by the research staff, the assigned therapist called the parents or the adolescent before the first appointment to introduce themselves, begin alliance building, and clarify any questions about treatment participation. All of the CYT interventions begin with an emphasis on empathy and skillful rapport building to build a strong therapeutic alliance and work through resistance related to the coercive influences that may have brought the adolescent to treatment.

The second strategy was for the therapist to speak for 5 to 10 minutes with any adolescent who had to wait more than 2 weeks to begin service (a delay sometimes caused by randomization and the cycles of starting new groups) to sustain his or her motivation for service involvement.

The third strategy was to remove as many environmental obstacles to treatment participation as possible by using geographically accessible service sites, providing assistance with transportation (that is, cab vouchers, bus tokens, picking adolescents up in the agency van), and providing or arranging childcare. Case management, whether provided by therapists, case managers (in the FSN intervention), or even during the screening activities of the research staff, was an essential medium of engagement for those families whose lives were most chaotic at the point of initial contact with the CYT project. Every effort was made to link what could be learned in treatment with what could help the immediate crisis presented by the family. The CYT interventions shared the message, "We have something that could help with some of these problems and improve the quality of life for you and your child."

The fourth and most important strategy was to actively engage the adolescents and families by creating strong therapeutic alliances, expressing interest in their participation (e.g., by weekly phone prompts for participation), finding a goal that the adolescent/family was interested in working on, expressing optimism in their capacity to change, and persisting in family contacts during the earliest signs of disengagement. FSN intervention staff felt that home visits were very important in initiating and sustaining the involvement of the most treatment-resistant families.

The fifth strategy was to provide a warm, collaborative, adolescent- and parent-friendly environment (with informal but respectful hosting; providing pizza and sodas as part of the dinner-hour adolescent and parent meetings) and to provide specific incentives for involvement in treatment (help with very specific problems, fully subsidized treatment, and token prizes for homework completion).

D. Safety Net Procedures. Safety net procedures involve strategies for recognizing and responding to adolescents who before or after entering outpatient care were thought to be in need of a higher level of care or allied services. We anticipated and experienced four scenarios that required such safety net procedures. The first involved emergency situations that might arise related to an adolescent's drug use during the course of the study. All parents were provided a laminated card listing signs of acute intoxication and oriented to procedures that could be used to respond to an emergency. The second scenario occurred when adolescents underreported the frequency and intensity of their drug use at intake but disclosed it after they were randomized and admitted to one of the therapies. The third scenario involved the frequency and intensity of use escalating after the adolescent had been admitted to outpatient treatment. The fourth scenario occurred when an adolescent's mental status deteriorated following admission, particularly where such deterioration posed the threat of harm to themselves or others. Safety net procedures were established at all four sites that: 1) ensured the periodic reassessment of the status of use and the appropriateness of the level of care to which clients were assigned, 2) ensured the availability and use of supervisory supports to formally reevaluate changes in clients' status and care needs, and 3) facilitated, when needed, moving an adolescent to a more structured and intense level of care or the addition of collateral services. Where alternative or additional services were thought to compromise evaluation of the effect of the CYT intervention, the adolescent/family were provided the additional services but the adolescent was no longer included in the study.

E. Concurrent Services. The exclusion of adolescents with severe psychiatric illness from the CYT study does not mean that all adolescents with psychiatric comorbidity were excluded from the CYT study. The majority of adolescents/families admitted to the CYT study presented with multiple problems, and the rate of psychiatric comorbidity of the adolescents admitted to the study was quite high. Forty-two percent met the criteria for attention deficit hyperactivity disorder, 55 percent met the criteria for conduct disorder, and 29 percent presented with multiple symptoms of traumatic stress (Tims, Hamilton, Dennis, & Brantley, 1999). Those adolescents who were referred for more intense services prior to randomization and who were not included in the CYT study were most likely to be excluded because they presented a high risk of harm to themselves or others. (These risks were identified through the participant screening form completed at intake and through the assessment instrument [GAIN] (Dennis, Webber, White, et al., 1996) and the interviews that were part of the intake process at all of the CYT service sites.)

The multiple problems presented by the CYT adolescents and their families raised an important clinical and research issue: How to respond to the clinical needs they presented without contaminating (through concurrent service involvement) the evaluation of the particular interventions in the CYT study. This problem was complicated further by the referral patterns of the agencies that linked adolescents with the CYT project. Acutely aware of the number and complexity of the problems many of these adolescents presented, many of these referral sources used a shotgun approach—simultaneously referring the adolescent/family to multiple treatments, hoping that the cumulative dose of services would have some positive effect on the child and family. These problems diminished through education of and negotiation with referral sources. It was a policy of the CYT study that adolescents would not be allowed to remain in the study who were receiving concurrent treatment whose primary focus was the problem of substance abuse or who were receiving services whose impact was judged by the local staff to inordinately confound the impact of the CYT intervention being provided. However, no adolescent had to be excluded from the study for such concurrent service involvement. Several adolescents who were treated simultaneously for collateral problems (e.g., being medicated for hyperactivity or depression) were allowed to enter and remain in the CYT study because the focus of the concurrent services was not on substance abuse or dependency.

F. Session Management. Efforts were made to ensure that issues related to the management of sessions that were not unique to the particular interventions would be handled in reasonably consistent ways across the sites. Where procedures were not the same, they were reviewed to ensure the differences would not confound outcomes. These discussions included how to respond to lateness, missed sessions (the criteria for dropping cases), intoxication, contraband, disruptive behavior, preexisting relationships between members, and a group session at which only one member is present.

Lateness was handled by degree, either by ensuring that the client got the minimal dose for that session or that the session was rescheduled. Missed sessions were rescheduled or, in the case of group interventions, provided as an abbreviated makeup session prior to the next scheduled session. (All services across the five modalities were expected to be completed within 14 weeks of the time of the first therapy session, with local TCs reviewing and approving any exceptions to this rule.)

All programs made intoxication and possession of contraband grounds for exclusion from that particular session and a flag for reassessment of the appropriateness of the current level of care. (While rare episodes of an intoxicated youth arriving for services did occur, these episodes were clinically managed without excluding the adolescent from continued service.) Only one adolescent per family was included in the CYT study, and preexisting relationships between participants in the group modalities were reviewed to determine if the prior history would undermine or enhance treatment. A group with only one member present was conducted in a 30- to 45-minute individual format covering the material that was scheduled for presentation. If an adolescent failed to appear for a family session, the session was conducted without the adolescent.

The TCs collectively sought and implemented general strategies that could enhance the effectiveness of sessions for all of the CYT therapies. Strategies that served to minimize problems and enhance session effectiveness included formalizing, posting, and consistently enforcing group/family norms on such issues as dress (banning drug/gang symbols on clothing) and language (profanity, drug argot). In the group interventions, the closed group structure made it particularly important to guard against negative influences within the peer cultures that evolved. A final issue was the appropriate level of contact between therapists and adolescents outside the intervention. The TCs decided that such contact should be minimized so as not to contaminate model fidelity by altering dose. More specifically, it was agreed that all extra-session contact should be responded to within the therapeutic framework of the particular intervention, channeled into upcoming sessions, documented, and brought to supervisors for review.

G. Gender and Cultural Adaptations. While there is significant momentum toward the development of standardized, empirically supported, and manual-based treatments (Wilson, 1998; Carroll, 1997), there is a simultaneous call for the refinement of standardized treatment that includes gender and cultural relevance and effectiveness (Orlandi, 1995). All of the CYT therapists noted making changes in their delivery of the manual-based treatments that were based on gender, cultural, and socioeconomic status (SES) appropriateness. Therapists in group interventions explicitly noted diversity issues in the group and incorporated respect for diversity into the ground rules established at the beginning of each group. The most frequently mentioned adaptations included:

- Changing the language of the session to reflect cultural or geographical norms
- Adding items to some worksheets to make them more applicable to urban youth
- Providing special writing and reading assistance to address illiteracy
- Slowing the pace, and adding repetitions of key ideas to accommodate learning impairments
- Developing examples and illustrations of key points that had greater gender, cultural, and SES relevance.

Therapists emphasized it was not the content of interventions that had changed; there were subtle changes in the way that content was framed or delivered.

H. Case Mix Issues. Therapists involved in the group interventions (MET/CBT5, MET/CBT12, FSN) also decided to monitor closely client mix issues according to gender, ethnicity, and other important dimensions. There was an effort to identify any potential iatrogenic effects of randomization (e.g., harassment, scapegoating, or other predatory targeting of a vulnerable group member by other group members), and to actively manage potential negative effects of group support for antisocial behavior (Dision, McCord, & Poulin, 1999). This was managed primarily by establishing and enforcing norms for group sessions.

I. Mutual Aid and Peer Support Groups. In contrast to Project MATCH, a 12-step facilitation therapy was not included in the CYT study, and there was some variation in the philosophies of the 5 interventions related to the desirability of mutual aid involvement by cannabis-involved adolescents. The ACRA, MDFT, and MET/CBT interventions do not directly encourage affiliation with addiction recovery support groups, but they do frame such involvement positively if the adolescent is already involved in such a group or self-initiates involvement during the course of treatment. FSN, while strongly encouraging parents to participate in Al-Anon, does not directly encourage adolescent clients to affiliate with Narcotics Anonymous

(NA) or Alcoholics Anonymous (AA). Information on local mutual support groups is provided simply as one of many community resources. There was more of an emphasis in all the CYT interventions on involvement in drug-free prosocial activities in general than on addiction recovery support group involvement.

J. Ethical Issues. The TC meetings also provided a venue to discuss and formulate responses to some of the complex ethical and legal issues that can arise in the treatment of adolescent substance abuse (White, 1993). Considerable time was spent discussing questions such as:

- What are the boundaries of confidentiality regarding disclosure of information about an adolescent to his or her parents?
- Do parents have a legal/ethical right to the results of their child's urine tests?
- What circumstances would constitute a duty to report or duty to intervene?
- What obligations, if any, do therapists have in responding to an adolescent's disclosures of past or planned criminal activity?
- How should therapists respond to reports of abuse of adolescents by a parent or to failures by child protection agencies to intervene to ensure the safety of the adolescent?

Discussion

Carroll and colleagues (1994, 1996, 1997) are to be commended for helping transfer the technology model of psychotherapy research to addiction treatment outcome studies. The CYT study greatly benefited from the earlier experience of Project MATCH in the use of this model. This paper has described a structure (the interface between a cross-site and cross-intervention TCs group and the CYT executive committee) and a process (monthly meetings of all the TCs and monitoring visits at each CYT study site) that were used to control contextual elements surrounding the experimental interventions. Our goal was to hold these contextual elements constant across the interventions in order to enhance our ability to measure the differences the experimental interventions produced on outcome measures. We wanted differences in outcomes to reflect differences in the interventions themselves and not factors incidental to the interventions.

While there were major research design elements (consistency in clinical data collection instruments and procedures, inclusion and exclusion criteria, and followup procedures) that helped control such variance across sites and interventions, we also sought to identify more subtle areas of potential contamination of the study. By generating consistent cross-intervention procedures to respond to lateness, missed sessions, disruptiveness, intoxication, and concurrent participation in other services, we were able to ensure a consistent and a more precise definition of the dose and type of services provided in, and collateral to, each intervention. By developing and monitoring safety net procedures across the sites and interventions, we were able to ensure timely and appropriate responses to the placement of a client in an inappropriate outpatient modality who needed a higher level of care, and to respond to acute episodes of clinical deterioration that warranted a similar change in the level of care. We found that the collaborative work of the TCs helped enhance the methodological rigor of the CYT study and helped establish a sound clinical infrastructure upon which each of the interventions was tested.

There are many aspects of the clinical management of the CYT project other than the efficacy of the particular interventions used that may have wide applicability to the field of adolescent substance abuse treatment. It is our view that many of the procedures to provide overall clinical management of randomized field trials have great clinical utility and are likely to become future baseline clinical practices in the treatment of adult and adolescent substance abuse disorders.

The technology model that, to date, has been used primarily as a means of ensuring methodological rigor in multisite field trials would seem to us to have enormous advantages for enhancing the quality of treatment and should be studied for potential adaptation to mainstream clinical practice. Those looking for ways to enhance the quality of adolescent substance abuse treatment would be well served to explore how the elements of this model could become part of the future definition of treatment as usual. Parents seeking help to address the substance abuse-related problems of their son or daughter ought to be able to expect that the theory behind the treatments they are offered can be articulated, and that their active ingredients can be defined. They should further be able to expect that these treatments have some degree of scientific support for their effectiveness, and that they will be delivered in a manner consistent with procedures whose effectiveness has been validated.

Increased demands for such accountability and fidelity by parents, policy makers, and funding agencies will likely make manual-based therapies the rule in the future, along with the training and adherence measures that accompany them. The technical aspects of cross-site clinical management of the CYT project have much to offer the field as a whole. The use of standardized assessment instruments that are capable of providing comprehensive assessment and treatment planning data should become a requirement of all adolescent treatment programs in the next decade. We would further commend the use of central (and booster) training, videotaping and adherence ratings as standard practices in supervision, and cross-site supervision as marvelous tools for training and professional development. Finally, we believe that rigorous followup (monitoring, feedback, and, where indicated, early reintervention) should move from the realm of clinical research to being an expectation, if not a requirement, of mainstream clinical practice. The idea of providing services without measuring outcomes will be incomprehensible in the very near future, and the technology to perform this task is rapidly emerging. Morale among staff working in the CYT project remained high, in part because of the near universal belief in the historical importance of this study and the climate of excitement and discovery that permeated the project. We believe that small field-based experiments to answer critical clinical questions, opportunities for cross-site sharing, and the opportunity to work on papers and presentations can similarly contribute to staff morale within local service organizations. We believe this milieu of curiosity, discovery, and contribution is transferable and sustainable in natural clinical settings. Routine outcome monitoring and field-based experiments, like the other items in this discussion, must simply be moved from the arena of clinical research to the arena of standard clinical practice. This transfer of technology from the research environment to the clinical practice environment, however, will not be simple.

If there is a single weak link in the current practice of addiction treatment that will slow this technology transfer, we believe it is in the arena of clinical supervision. Comprehensive assessments, science-guided treatment planning, empirically validated and manual-based therapies, regular adherence measurement and monitoring, using clients' response-to-treatment data and supervision to individualize and refine standard interventions, and rigorous posttreatment followup (and early reintervention, where called for) all flow from the clinical infrastructure at the core of which is a clinical supervisor. If we can elevate the quality of clinical supervision in the field—the selection, training, and support of clinical supervisors to do true clinical supervision—to that of clinical supervision in controlled clinical trials, we will be able to channel knowledge from clinical research to clinical practice.

Conclusions

Clearly defining the demographic and clinical characteristics of client populations, presenting the active ingredients in a manual format and procedures inherent in particular treatments for those populations, monitoring therapists' adherence to such procedures, controlling contextual influences that can influence treatment outcomes, and conducting rigorous and sustained followup to determine clients' responses to particular interventions collectively hold great promise in moving the treatment of adolescent substance abuse from the status of a folk art to that of a clinical science. The technologies used to build this science may themselves offer great potential in enhancing the quality of adolescent substance abuse treatment programs if they can be adapted for routine use in the clinical setting. The CYT study confirms the importance that these new tools can and will have in the future clinical management of adolescent substance abuse treatment.

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